

Patient's Name \_\_\_\_\_

MRN \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender M / F

Physician \_\_\_\_\_

Physician's Telephone \_\_\_\_\_

**CLINICAL INFORMATION (check all that apply)**

Please return the completed form with the patient specimen or fax to 505.938.8410.

<p><b>Perinatal History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Prematurity</li> <li><input type="checkbox"/> IUGR</li> <li><input type="checkbox"/> Oligohydramnios</li> <li><input type="checkbox"/> Polyhydramnios</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Growth</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Failure to thrive</li> <li><input type="checkbox"/> Overgrowth</li> <li><input type="checkbox"/> Short stature</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Fine motor delay</li> <li><input type="checkbox"/> Gross motor delay</li> <li><input type="checkbox"/> Speech delay</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Cognitive</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Learning disability</li> <li><input type="checkbox"/> Intellectual disability/MR</li> <li><input type="checkbox"/> IQ/DQ (if known):</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Behavioral</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Autistic features</li> <li><input type="checkbox"/> Autism spectrum disorder</li> <li><input type="checkbox"/> Oppositional defiant disorder</li> <li><input type="checkbox"/> Obsessive-compulsive disorder</li> <li><input type="checkbox"/> ADHD</li> <li><input type="checkbox"/> Pervasive developmental delay</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b>Neurological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Ataxia/dystonia/chorea</li> <li><input type="checkbox"/> Hypotonia</li> <li><input type="checkbox"/> Hypertonia</li> <li><input type="checkbox"/> Neural tube defect</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Spasticity</li> <li><input type="checkbox"/> Structural brain anomaly</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Cardiac</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> ASD</li> <li><input type="checkbox"/> VSD</li> <li><input type="checkbox"/> Coarctation of aorta</li> <li><input type="checkbox"/> Hypoplastic left/right heart</li> <li><input type="checkbox"/> Tetralogy of Fallot</li> <li><input type="checkbox"/> AV canal defect</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Craniofacial</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Cleft lip+/- cleft palate</li> <li><input type="checkbox"/> Cleft palate alone</li> <li><input type="checkbox"/> Coloboma</li> <li><input type="checkbox"/> Craniosynostosis</li> <li><input type="checkbox"/> Dysmorphic facial features</li> <li><input type="checkbox"/> Ear malformation</li> <li><input type="checkbox"/> Macrocephaly</li> <li><input type="checkbox"/> Microcephaly</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Cutaneous</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Hyperpigmentation</li> <li><input type="checkbox"/> Hypopigmentation</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Contractures</li> <li><input type="checkbox"/> Club foot</li> <li><input type="checkbox"/> Diaphragmatic hernia</li> <li><input type="checkbox"/> Limb anomaly</li> <li><input type="checkbox"/> Polydactyly</li> <li><input type="checkbox"/> Syndactyly</li> <li><input type="checkbox"/> Scoliosis</li> <li><input type="checkbox"/> Vertebral anomaly</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Gastroschisis</li> <li><input type="checkbox"/> Omphalocele</li> <li><input type="checkbox"/> Hirschsprung disease</li> <li><input type="checkbox"/> Pyloric stenosis</li> <li><input type="checkbox"/> Tracheoesophageal fistula</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> Within normal limits</li> <li><input type="checkbox"/> Ambiguous genitalia</li> <li><input type="checkbox"/> Hydronephrosis</li> <li><input type="checkbox"/> Hypospadias</li> <li><input type="checkbox"/> Kidney malformation</li> <li><input type="checkbox"/> Cryptorchidism</li> <li><input type="checkbox"/> Urethra/ureter obstruction/malformation</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Family History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Not evaluated</li> <li><input type="checkbox"/> No relevant history</li> <li><input type="checkbox"/> Parents with ≥3 miscarriages</li> <li><input type="checkbox"/> Relatives with similar history</li> <li><input type="checkbox"/> Familial chromosome change</li> <li><input type="checkbox"/> Consanguinity</li> <li><input type="checkbox"/> Other: _____</li> </ul>
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Clinical Description - include any additional information not provided above (include karyotype if known):

Questions? Please contact TriCore's molecular diagnostics laboratory at 505.938.8684 or cytogenetics laboratory at 505.938.8430.