



THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform biochemical genetic testing.
For electronic orders only, please fill out and submit with the electronic packing list.

PATIENT HISTORY FOR BIOCHEMICAL GENETIC TESTING

Client Number _____

Patient Name _____ Date of Birth _____ Gender [] Female [] Male

Physician _____ Physician Phone (_____) _____

Genetic Counselor _____ Counselor Phone (_____) _____

Comments or Special Instructions _____

Referring Diagnosis _____
