# Postnatal Chromosome Microarray Testing
## Patient Clinical Information Form

**Instructions:** The accurate interpretation and reporting of genetic test results is contingent upon the reason for referral, clinical information provided, and family history. To help provide the best possible service, please check applicable clinical information below. **Send this page with the specimen or return by fax to the laboratory at the contact number below. If a karyotype has been performed, please record the results at the bottom of the form.**

**Diagnostic Genomics. PP Block Level 2, QEII MC  Phone: (08) 6383 4221  Fax: (08) 9346 4029**

**Test Request Date:** _____ **Referring Physician:** _____ **Physician Specialty:** _____

| Patient Last Name: | Patient First Name: | UMRN: | Gender: ☑ Male ☐ Female | Date of Birth: |
|---|---|---|---|---|
| | | | | |

**Clinical Information** (Please check all that apply)**:**

**Perinatal History:**
- □ Prematurity
- □ IUGR
- □ Oligohydramnios
- □ Polyhydramnios
- □ Other (list):

_____

**Growth:**
- □ Failure to thrive
- □ Overgrowth
- □ Short stature
- □ Other (list):

_____

**Developmental:**
- □ Fine motor delay
- □ Gross motor delay
- □ Speech delay
- □ Other (list):

_____

**Cognitive / Behaviour:**
- □ Learning disability
- □ Intellectual disability/MR
  List DQ/IQ, if known:
- □ Autistic features
- □ Autism spectrum
- □ Oppositional-defiant
- □ Obsessive-compulsive
- □ Other (list):

_____

**Neurological:**
- □ Structural brain anomaly
- □ Neural tube defect
- □ Cerebral palsy
- □ Spasticity
- □ Ataxia
- □ Dystonia/
- □ Hypotonia
- □ Seizures
- □ Other (list):

_____

**Cardiac:**
- □ ASD
- □ VSD
- □ AV canal defect
- □ Coarctation of the aorta
- □ Hypoplastic left heart
- □ Other (list):

_____

**Craniofacial:**
- □ Cleft lip □ Cleft palate
- □ Coloboma of eye
- □ Craniosynostosis
- □ Dysmorphic facial features
- □ Ear malformations
- □ Macrocephaly
- □ Microcephaly
- □ Other (list):

_____

**Musculoskeletal:**
- □ Contractures
- □ Club foot
- □ Diaphragmatic hernia
- □ Limb anomaly
- □ Polydactyly
- □ Syndactyly
- □ Scoliosis
- □ Vertebral anomaly
- □ Other (list):

_____

**Gastrointestinal:**
- □ Gastroschisis
- □ Hirschprung disease
- □ Omphalocele
- □ Pyloric stenosis
- □ Tracheoesophageal fistula
- □ Other (list):

_____

**Genitourinary:**
- □ Ambiguous genitalia
- □ Hydronephrosis
- □ Hypospadias
- □ Kidney malformation
- □ Undescended testis
- □ Urethral malformation
- □ Ureteral obstruction
- □ Other (list):

_____

**Cutaneous:**
- □ Hyperpigmentation
- □ Hypopigmentation
- □ Other (list):

_____

**Clinical features suggestive of mosaicism?**
- □ No
- □ Yes
- □ If yes, list features:

_____
_____
_____

**Family History:**
- □ Parents with ≥ 2 miscarriages
- □ Other relatives with similar clinical history (please explain):

_____
_____
_____

**Hearing / Vision:**
- □ Hearing loss
  Specify:_____
- □ Abnormality of Vision
  Specify:_____
- □ Abnormality of Eye Movement
  Specify: _____
- □ Other (list):

_____

**Clinical description:** Please include any additional relevant clinical information not provided above (list karyotype if known)**:**

As a participant in the ISCA (International Standards for Cytogenomic Arrays) Consortium, this Diagnostic Genomics laboratory contributes submitted clinical information and test results to a HIPAA compliant, de-identified public database as part of the NIH's effort to improve understanding of the relationship between genetic changes and clinical symptoms. Confidentiality is maintained. Patients may request to opt-out of this scientific effort by: 1) checking the box below; or 2) contacting the laboratory at (08) 6383 4221 and asking to speak with a laboratory genetic counselor. **Please call with any questions.**

☐ **Indicate refusal for inclusion in these efforts by checking this box. If the box is not marked, data will be anonymized and used.**