ARUP LABORATORIES

An enterprise of the University of Utah and its Department of Pathology

MANUAL ORDER

500 Chipeta Way • Salt Lake City, Utah 84108-1221
Phone: (800) 522-2787 • Fax: (801) 584-5207 • www.aruplab.com

13276
RCHSD NEWBORN SCREENING
3020 CHILDRENS WAY MC5116
SAN DIEGO, CA 92123

PATIENT NAME (LAST) **(FIRST)** **(M.I.)**

NBS ACCESSION **LAB I.D. NUMBER**

BIRTHDATE _____ - _____ - _____ (mo / day / yr)

SEX

REFERRING PHYSICIAN

COMMENTS, SPECIAL INSTRUCTIONS

SPECIMEN TRANSPORT

☐ **Refrigerated**

SPECIMEN COLLECTION

[ ] AM

[ ] PM

DATE: _____ - _____ - _____ (mo / day / yr) **TIME:** _____

SPECIMEN TYPE **(Minimum: Two, 2 mL whole blood tubes)**

WHOLE BLOOD SOURCE:

☐ **Green (Heparin)** ☐ **Lavendar (EDTA)**

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH—GALACTOSEMIA TESTING

0080125 ☒ Galactose-1-Phosphate Uridyltransferase
0051176 ☐ Galactosemia, GALT Gene Mutations

Required Patient History

HAS THE PATIENT BEEN TRANSFUSED?

☐ No ☐ Yes Date: _____ Time: _____

PATIENT'S ETHNICITY

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

DOES THE PATIENT HAVE SYMPTOMS OF GALACTOSEMIA?

☐ No ☐ Yes ☐ Unknown

If yes, list symptoms _____

DOES THE PATIENT HAVE A FAMILY HISTORY OF GALACTOSEMIA?

☐ No ☐ Yes ☐ Unknown

If yes, please answer the following questions:

- What is the relationship of the patient to the affected individual?
  ☐ Child ☐ Father ☐ Mother ☐ Sibling ☐ Other

- If the affected relative is a son/daughter, list the child's name and date of birth:

Name: _____ DOB _____

NBS accession of child: _____

- If known, list the galactose-1-phosphate uridyltransferase (GALT) gene mutation(s) in the affected relative:

_____

COLLECTION FACILITY NAME

_____ _____ ( ) _____
Contact Name Phone Number

NUMBER OF SPECIMENS SUBMITTED _____

TOTAL NUMBER OF TESTS ORDERED _____

THIS BOX FOR ARUP LABORATORIE'S USE ONLY

Qty _____ **RT** **R** **F** **ID#** _____

Ser **Pla** **WB** **Urine** **Stool** **CSF** **S/P**

Tissue **SST** **Other** _____ **Wrapped**