To avoid testing delays, this form must be completed in its entirety for all orders.

Quest Diagnostics™

Familial Hypercholesterolemia (FH) Clinical History Form

Client Account Number: _____ **Client Name:** _____

Patient Name: _____ **Patient DOB:** _____ **Patient Phone:** _____

Ethnicity (please select all that apply)

☐ African American/Black ☐ Native American ☐ Western/Northern European ☐ Middle/Near Eastern
☐ Hispanic ☐ Asian ☐ Eastern/Central European ☐ Jewish (Ashkenazi) ☐ Other _____

Genetic Testing History

Has the patient had previous genetic testing associated with FH (including *LDLR, APOB,* & *PCSK9*)?	☐ Yes ☐ No	**If Yes,** a copy of the patient's previous genetic test report must be faxed (1.855.422.5181) or emailed (Preauthorization@QuestDiagnostics.com)
Has anyone in the family tested positive for a genetic variant associated with FH (including *LDLR, APOB,* & *PCSK9*)?	☐ Yes ☐ No	**If Yes**, a copy of the family member's genetic test report must be faxed (1.855.422.5181) or emailed (Preauthorization@QuestDiagnostics.com) Please note the family member's relation to the patient on the report.
		If Yes, will a blood sample from the family member that tested positive (positive control) be provided? ☐ Yes*[T] ☐ No

*If Yes, please call 1.866.GENE.INFO prior to sending a specimen to discuss this order
[T]ACMG guidelines, CAP, and CLIA regulatory provisions recommend use of a positive control

Patient History (Please check here if no personal history ☐)

Does patient meet the diagnostic criteria for FH based on Dutch Lipid Criteria Network, or MEDPED, or Simon Broome? ☐ Yes ☐ No

Personal History of	Please check all boxes that apply	Age at Diagnosis
☐ Elevated Cholesterol	☐ LDL-C level _____ ☐ Total cholesterol level_____	
☐ Coronary Heart Disease (CHD)	☐ Acute myocardial infarction (AMI) ☐ Myocardial infarction (silent MI) ☐ Unstable angina ☐ Coronary revascularization procedure (PCI or CABG) ☐ Atherosclerotic cardiovascular disease	
☐ Vascular Disease	☐ Cerebral ☐ Peripheral	
☐ Tendon Xanthoma(s)		
☐ Corneal Arcus		
☐ Other		

Family History (Please check here if no personal history ☐)

Relationship to Patient	Maternal	Paternal	Elevated Cholesterol?	Cardiac Disease (please describe, including Tendon Xanthoma and Corneal Arcus)	Age at Diagnosis	Living or Deceased (please provide age at death)
	☐	☐	☐			
	☐	☐	☐			
	☐	☐	☐			
	☐	☐	☐			
	☐	☐	☐			

Patient Acknowledgement

I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be financially responsible for portions of this test not covered by my insurance, and that Quest will contact me prior to test start ONLY if my responsibility for coinsurance, deductible, and/or non-covered service is estimated to be greater than $350. **Tests without a signature will NOT be processed.**

Date: _____ Patient Name (Print): _____

Patient Signature: _____

Please fax or email the completed form to 1.855.422.5181 or Preauthorization@QuestDiagnostics.com
For questions, please contact 1.855.509.4909 or email us at Preauthorization@QuestDiagnostics.com

Familial Hypercholesterolemia (FH) Clinical History Form
Frequently Asked Questions

Why am I completing the (FH) Clinical History Form?

Genetic testing may require special authorization from insurance companies. To help with this, please fill out the whole form. We understand that this form asks for very personal information. This information is needed for Quest Diagnostics to both work with the insurance company and interpret the results.

How do I know which box(es) to check in the ethnicity section?

Ethnic background is determined by which countries someone's relatives are from originally. Below is a chart that will help you determine which box(es) to check.

Ethnicity	Description
African American/Black	African, African American
Native American	Native American, American Indian
Western/Northern European	Austrian, British/English, Canadian, Danish, Dutch, Finnish, French, French-Canadian, Italian, Irish, Norwegian, Portuguese, Scandinavian, Scottish, German, Sephardic, Spanish, Swedish, Welsh
Middle/Near Eastern	Arabic, Armenian, Egyptian, Iranian, Iraqi, Pakistani, Persian, Saudi Arabian, Syrian
Hispanic	Bahamian, Brazilian, Caribbean, Colombian, Cuban, Dominican, Mexican, Puerto Rican, Haitian, Hispanic, Latin American
Asian	Chinese, Indian, Indonesian, Malaysian, Filipino, Samoan, Hawaiian, Vietnamese, Japanese
Eastern/Central European	Czech, Polish, Romanian, Russian, Greek, Hungarian
Jewish (Ashkenazi)	A person of Jewish heritage who is (or whose family is) ethnically German, French, or Eastern European

What should I do with the form when I am done filling it out?

Give the form to the person drawing blood at the time of the blood draw. This will ensure that the form goes with the blood to the Lab.

What happens next?

Your test results will be sent to the doctor when they are ready.