Family Insight Program (FIP)
Pedigree Form

Patient name: _____

Patient DOB: _____ Accession#/Patient ID: _____

This form should be used by the healthcare provider and patient to gather the necessary family history information required for participation in the Family Insight Program. Please list all of the patient's relatives, both affected (with the disease in question) and unaffected, using the form below.

In lieu of this completed form, a detailed, 3-generation pedigree may be faxed to **1.774. 843.5657**.

Number of family members (related by blood, either living or deceased)

Grandparents: **4**	Brothers:
Mother: **1**	Daughters:
Father: **1**	Sons:
Aunts (either side of family):	Half-sisters:
Uncles (either side of family):	Half-brothers:
Sisters:	

Immediate family (parents, siblings, children)

Relation	Name	Twin? (Y/N)	Related health condition	Age at diagnosis	Diagnosis confirmed medically? (Y/N)	Living? (Y/N)	Age at death

Patient name: _____

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Mother's side (mom's parents and siblings)

Relation	Name	Twin? (Y/N)	Related health condition	Age at diagnosis	Diagnosis confirmed medically? (Y/N)	Living? (Y/N)	Age at death

Father's side (dad's parents and siblings)

Relation	Name	Twin? (Y/N)	Related health condition	Age at diagnosis	Diagnosis confirmed medically? (Y/N)	Living? (Y/N)	Age at death

Completed Pedigree Form instructions

Please fax the completed form to **1.774.843.5657**. A Genomic Science Specialist will follow up with the healthcare provider facilitating this application.

Contact us

For questions regarding the Family Insight Program, please contact **1.866.436.3463** and ask to speak with a Genomic Science Specialist.

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