ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform retinitis pigmentosa/leber congenital amaurosis testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR RETINITIS PIGMENTOSA/LEBER CONGENITAL AMAUROSIS TESTING

Patient Name _____ Date of Birth _____/_____ /_____ Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

Genetic Counselor _____ Counselor Phone (_____)_____

Patient's Ethnicity (check all that apply)

[ ] African American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

Suspected diagnosis:

[ ] Retinitis Pigmentosa [ ] Leber Congenital Amaurosis [ ] Cone-rod dystrophy [ ] Usher syndrome
[ ] Stargardt disease [ ] Meckel-Gruber syndrome [ ] Nephronophthisis [ ] Joubert syndrome
[ ] Macular atrophy [ ] Macular dystrophy [ ] Adult vitelliform MD [ ] Retinitis punctata albescans
[ ] Coroidal sclerosis [ ] S-cone syndrome [ ] Bothnia dystrophy [ ] Oguchi disease
[ ] Other _____

Is the patient SYMPTOMATIC? [ ] No [ ] Yes - if yes, are symptoms [ ] bilateral or [ ] unilateral
Age of onset: _____

Please check all symptoms that apply:

[ ] "night blindness" [ ] loss of peripheral vision ("tunnel vision") [ ] macular lesions
[ ] macular degeneration [ ] dust-like particles in the vitreous [ ] cystoid macular edema
[ ] white spots in the retina [ ] posterior subcapsular cataracts [ ] hyaline bodies
[ ] exudative vasculopathy [ ] nystagmus [ ] sluggish pupillary response
[ ] "oculo-digital sign" [ ] photophobia [ ] hyperopia
[ ] abnormal ERG [ ] keratoconus [ ] RPE granularity
[ ] retinal vessel attenuation [ ] sensorineural hearing loss [ ] sinopulmonary infection

Other Symptoms:_____

Has the patient undergone previous genetic testing for the above disorder? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test performed, genes tested and results:_____

Does the patient have a FAMILY HISTORY of RP/LCA or a related disorder? [ ] No [ ] Yes [ ] Unknown
If yes, **please attach PEDIGREE or** COMPLETE BELOW:

RELATIONSHIP to the patient	Age at Dx	Symptoms	Dx confirmed by DNA testing?	
_____	_____	_____	[ ] No	[ ] Yes*
_____	_____	_____	[ ] No	[ ] Yes*
_____	_____	_____	[ ] No	[ ] Yes*

Circle the test you intend to order.

2007085 Retinitis Pigmentosa/Leber Congenital Amaurosis Panel, Sequencing and Deletion/Duplication, 53 Genes: Next generation sequencing and microarray coverage of 53 genes associated with RP and LCA.

2001961 Familial Mutation, Targeted Sequencing: Targeted sequencing for variants previously identified in a family member; a copy of the relative's lab result is REQUIRED. Contact an ARUP genetic counselor prior to ordering.

For questions, contact an ARUP genetic counselor at (800) 242-2787, ext. 2141

Master Label