

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?	
_____	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes*
_____	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes*
_____	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> 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

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