ARUP LABORATORIES

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

PATIENT HISTORY FOR DUCHENNE/BECKER MUSCULAR DYSTROPHY GENETIC 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 _____

Does the patient have SYMPTOMS? (check all that apply) [ ] No [ ] Yes [ ] Unknown

[ ] Muscle weakness (Age of onset: _____) [ ] Calf hypertrophy [ ] Intellectual disability
[ ] Generalized motor delay [ ] Flexion contracture of the elbows [ ] Wheelchair dependent
[ ] Myalgia/muscle cramping [ ] Difficulty walking/abnormal gait [ ] Other _____
[ ] Cardiomyopathy [ ] Gower sign

Laboratory findings:

Serum creatine phosphokinase (CK):	[ ] Abnormal _____U/L	[ ] Normal	[ ] Not performed
Muscle histology	[ ] Abnormal _____	[ ] Normal	[ ] Not performed
Dystrophin immunohistochemistry:	[ ] Abnormal _____	[ ] Normal	[ ] Not performed
Dystrophin quantity:	[ ] Abnormal _____ %	[ ] Normal	[ ] Not performed

FAMILY HISTORY? [ ] Duchenne muscular dystrophy [ ] Becker muscular dystrophy
[ ] Dilated cardiomyopathy [ ] Neither [ ] Unknown

If yes, **attach a** PEDIGREE or specify the relatives' **RELATIONSHIP** to the patient. _____
Is the relative? [ ] a carrier [ ] affected
If affected, list symptoms and age of onset: _____
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown

Has the patient undergone previous DNA testing for muscular dystrophy/cardiomyopathy?
[ ] No [ ] Yes [ ] Unknown

If yes, please describe test(s) and results:_____

Circle the test you intend to order:

Recommended first tier testing for Duchenne/Becker muscular dystrophy:	
2011241	*DMD* Deletion/Duplication with Reflex to Sequencing: Clinical sensitivity is approximately 95%
2011235	*DMD* Deletion/Duplication: Clinical sensitivity is 55%-90%
2011153	*DMD* Sequencing: Clinical sensitivity is 10%-35%
Targeted testing for known mutation (laboratory report from affected family member REQUIRED)	
2011235	*DMD* Deletion/Duplication- Tests for a deletion/duplication previously identified in a family member
2001961	Familial Mutation, Targeted Sequencing- Tests for sequence variation previously identified in a family member

Other test not listed: _____

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

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