ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PRIMARY CILIARY DYSKINESIA/HETEROTAXY TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply and describe)

Pulmonary symptoms:

- ☐ Neonatal respiratory distress
- ☐ Chronic airway infections
- ☐ Chronic wet cough (age of onset: _____)
- ☐ Chronic nasal congestions (age of onset: _____)
- ☐ Obstructive lung disease
- ☐ Bronchiectasis
- ☐ Other: _____

Laterality defects:

- ☐ Situs inversus totalis
- ☐ Heterotaxy (situs ambiguous), describe: _____

- ☐ Heart defect (describe: _____)
- ☐ Infertility (describe: _____)
- ☐ Other symptoms or birth defects: _____

Has the patient had any of the following tests? ..... ☐ No ☐ Yes ☐ Unknown

- ☐ Sweat chloride testing (describe results: _____)
- ☐ Nasal nitric oxide measurements (describe results: _____)
- ☐ Ciliary ultrastructure via electron microscopy (describe results: _____)
- ☐ Ciliary motility via high-speed video microscopy (describe results: _____)
- ☐ Other evaluations: _____

Has the patient undergone previous germline DNA testing ..... ☐ No ☐ Yes ☐ Unknown

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

Is there any relevant family history of primary ciliary dyskinesia, heterotaxy, or related symptoms?

..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

_____

_____

Has DNA testing been performed for the family member(s) ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial variant testing).

Master Label

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