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 FAMILIAL TRANSTHYRETIN (TTR) AMYLOIDOSIS

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 [ ] Caucasian [ ] Hispanic
[ ] Japanese [ ] Middle Eastern [ ] Portuguese [ ] Other _____

Does the patient have symptoms of any of the following TTR phenotypes? [ ] No [ ] Yes
[ ] TTR amyloid polyneuropathy [ ] TTR cardiac amyloidosis [ ] TTR leptomeningeal amyloidosis
[ ] TTR oculoleptomeningeal amyloidosis [ ] Other _____

Does the patient have SYMPTOMS of TTR Amyloidosis? [ ] No [ ] Yes; please check all that apply

[ ] Peripheral sensori/motor neuropathy
- [ ] Loss of sensation in feet or hands
- [ ] Prickling/ burning/ numbness in extremities
- [ ] Muscle weakness
- [ ] Difficulty walking or using arms/ hands

[ ] Autonomic neuropathy
- [ ] Sweating too much or too little
- [ ] Vomiting/ delayed gastric emptying
- [ ] Constipation /diarrhea
- [ ] Sexual impotence
- [ ] Orthostatic fainting
- [ ] Urinary incontinence or retention

[ ] Nephropathy
[ ] Vitreous opacities

[ ] CNS findings
- [ ]Visual impairment
- [ ] Dementia
- [ ] Ataxia/Spasticity
- [ ] Seizures
- [ ] Psychosis
- [ ] Hydrocephalus

[ ] Cardiac Disease
- [ ] Cardiomegaly
- [ ] Conduction block
- [ ] Angina
- [ ] Congestive heart failure
- [ ] Aortic dissection/dilatation

[ ] Other_____

Has the patient undergone other laboratory testing for TTR Amyloidosis? [ ] No [ ] Yes [ ] Unknown
Congo Red Staining/Immunohistochemistry: [ ] Normal [ ] Abnormal _____ [ ] Uncertain_____
Serum TTR Testing by Mass Spec: [ ] Normal [ ] Abnormal _____ [ ] Uncertain_____

Does the patient have a FAMILY HISTORY of TTR Amyloidosis? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family members to the patient and detail the symptoms/age of onset in each symptomatic relative:

_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, please attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing)

Circle the test you intend to order

Recommended first tier testing for ATTR:	
2014035	**Familial Transthyretin Amyloidosis (*TTR*) Sequencing- detects>99% of mutations causative for TTR Amyloidosis**
Targeted testing for known mutation (laboratory report from family member REQUIRED)	
2001961	**Familial Mutation, Targeted Sequencing**: Targeted testing for a known familial sequence mutation. Copy of laboratory result of affected relative must be submitted with the sample.

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

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