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 WILSON DISEASE (*ATP7B*) 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 of Wilson disease? [ ] No [ ] Yes; please check all that apply

[ ] Kayser-Fleisher rings
[ ] Liver disease:
  [ ] Hepatomegaly [ ] Hepatitis [ ] Jaundice [ ] Cirrhosis [ ] Liver failure
[ ] Neurological findings:
  [ ] Abnormal movements [ ] Difficulty with motor tasks [ ] Rigidity
[ ] Psychiatric disease:
  [ ] Anxiety/depression [ ] Cognitive/memory problems [ ] Personality/behavioral changes
[ ] Other; describe: _____

Laboratory findings:

Serum ceruloplasmin concentration:	[ ] Low	[ ] High	[ ] Normal	Value:_____ mg/dL	[ ] Unknown
Serum copper concentration:	[ ] Low	[ ] High	[ ] Normal	Value:_____ ug/dL	[ ] Unknown
Free (direct) copper concentration:	[ ] Low	[ ] High	[ ] Normal	Value:_____ ug/dL	[ ] Unknown
24-hour urine copper concentration:	[ ] Low	[ ] High	[ ] Normal	Value:_____ ug/24hrs	[ ] Unknown
Hepatic copper concentration:	[ ] Low	[ ] High	[ ] Normal	Value:_____ ug/g	[ ] Unknown

Does the patient have a FAMILY HISTORY of Wilson disease? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the relatives' RELATIONSHIP to the patient. List their symptoms & age of onset:

_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
Has the patient undergone previous DNA testing for Wilson disease? [ ] No [ ] Yes [ ] Unknown

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

Circle the test you intend to order OR write the test name and number below:

Recommended first tier testing for Wilson disease:	
2010716	Wilson Disease (ATP7B) Sequencing – detects 98% of mutations causing Wilson disease.
Targeted testing for known mutation (laboratory report from family member REQUIRED)	
2001976	Familial Mutation, Targeted Sequencing – targeted testing for a known familial sequence mutation

Other test not listed: _____

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

Master Label