ARUP LABORATORIES

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

PATIENT HISTORY FOR FREEMAN-SHELDON SYNDROME TESTING

Patient's Name _____ Date of Birth _____/_____ /_____ Gender [ ] F [ ] M

Physician _____ Physician's Phone (_____) _____Practice Specialty_____

Genetic Counselor _____ Counselor's 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 ? [ ] No [ ] Yes (check all that apply)

[ ] Small pinched mouth
[ ] H-shaped dimpling of the chin
[ ] Ulnar deviation of the wrists and fingers
[ ] Camptodactyly
[ ] Clubfoot
[ ] Underdeveloped/absent flexion creases of the hands
[ ] Hips/elbow contractures
[ ] Dental crowding
[ ] Scoliosis
[ ] Strabismus
[ ] Congenital hearing loss
[ ] Inguinal hernia
[ ] Cryptorchidism
[ ] Other _____

_____

Does the patient have a FAMILY HISTORY of [ ] **Freeman-Sheldon Syndrome** [ ] Contractures
[ ] Neither [ ] Unknown

If yes, please attach PEDIGREE or specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic relative.

_____

_____

Has the patient undergone previous testing for Freeman-Sheldon syndrome? [ ] No [ ] Yes
If yes, please describe test(s) and results

_____

Freeman-Sheldon Syndrome Testing

2002662 Freeman-Sheldon Syndrome *(MYH3)* Sequencing Exon 17
Offer to patients who have multiple joint and facial contractures. Clinical sensitivity approximately 70%.

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

Master Label