ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform primary congenital glaucoma (*CYP1B1*) testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR PRIMARY CONGENITAL GLAUCOMA (*CYP1B1*) 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? [ ] No [ ] Yes (check all that apply)

[ ] Congenital glaucoma (age of onset: _____, [ ] Bilateral [ ] Unilateral)
[ ] Elevated intraocular pressure
[ ] Enlargement of the globe (buphthalmos)
[ ] Corneal edema/clouding
[ ] Haab stiae (tear in Descemet membrane)
[ ] Thinning of the anterior sclera
[ ] Abnormally deep anterior chamber
[ ] Photophobia (sensitivity to light)
[ ] Excessive tearing (ephiphora)
[ ] Involuntary eyelid spasms (blepharospasm)
[ ] Other _____

Has Peter's anomaly (anterior segment dysgenesis) been ruled out? [ ] No [ ] Yes [ ] Unsure [ ] N/A

Does the patient have a FAMILY HISTORY of Primary Congenital Glaucoma? [ ] No [ ] Yes [ ] Unknown
If yes, what is the **RELATIONSHIP** of the affected family member(s) to the patient? _____

Has DNA testing for primary congenital glaucoma been performed for affected family member(s)?
[ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results _____

Has the patient undergone previous DNA testing for Primary Congenital Glaucoma? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results _____

Circle the PRIMARY CONGENITAL GLAUCOMA test you intend to order.

0051476 Glaucoma, Primary Congenital (*CYP1B1*) Sequencing
Diagnostic testing for symptomatic patients; clinical sensitivity 20-100% in familial cases, 10-15% in isolated cases.

2001961 Familial Mutation, Targeted Sequencing
Tests for a *CYP1B1*sequence change identified in a family member; copy of relative's lab result is REQUIRED.

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

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