ARUP LABORATORIES

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

PATIENT HISTORY FOR LAMINOPATHIES (*LMNA)* GENE TESTING

Patient's 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_____

PATIENT'S CLINICAL DIAGNOSIS

[ ] Hutchinson-Gilford Progeria [ ] Emery-Dreifuss Muscular Dystrophy [ ] Limb Girdle Muscular Dystrophy
[ ] Charcot-Marie-Tooth [ ] Familial Partial Lipodystrophy [ ] Dilated Cardiomyopathy
[ ] Mandibulo-Acral Dysplasia [ ] Atypical Werner Syndrome [ ] Restrictive Dermopathy
[ ] Other _____

Does the patient have SYMPTOMS? [ ] No [ ] Yes, check all that apply

[ ] Premature aging [ ] Failure to Thrive [ ] Growth retardation
[ ] Alopecia [ ] Hypogonadism [ ] Cataracts
[ ] Joint degeneration [ ] Joint contractures [ ] Fetal akinesia
[ ] Progressive muscle weakness/wasting [ ] Distal muscle weakness [ ] Absent tendon reflexes
[ ] Cardiac conduction defects [ ] Impaired systolic function [ ] Progressive ventricular dilation
[ ] Excess fat on face/neck [ ] Loss of subcutaneous fat from extremities
[ ] Mottled cutaneous pigmentation [ ] Craniofacial and skeletal anomalies, specify: _____
[ ] Other: _____

Does the patient have a FAMILY HISTORY of any of the above symptoms? [ ] No [ ] Yes [ ] Unknown
If yes, attach a 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 DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, attach copy of the relative's DNA laboratory result <u>(REQUIRED for familial mutation testing).</u>

Has the patient undergone previous DNA testing for a Laminopathy? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the gene/disorder, methodology, and results_____

<u>Circle the test you intend to order.</u>

2004543 *LMNA*-Related Disorders (*LMNA)* Sequencing
Sequence analysis of *LMNA* coding regions; clinical sensitivity is dependent upon the specific *LMNA*-related disorder.

2004539 *LMNA*-Related Disorders (*LMNA)* Deletion/Duplication
For patients with clinical features of non-X linked EDMD2, LGMD1B, or inherited DCM and negative *LMNA* sequencing result, clinical sensitivity varies with specific *LMNA*-related disorder. **Also order for familial *LMNA* large deletion or duplication testing.**

2001961 Familial Mutation, Targeted Sequencing
Tests for a *LMNA* 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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