ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

LAMINOPATHIES (*LMNA*) GENE TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Physician: _____ **Physician Phone:** _____

Practice Specialty: _____ **Physician Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ White ☐ Middle Eastern ☐ Other: _____

Clinical Diagnosis

☐ Atypical Werner syndrome
☐ Charcot-Marie-Tooth
☐ Dilated cardiomyopathy
☐ Emery-Dreifuss muscular dystrophy
☐ Familial partial lipodystrophy
☐ Hutchinson-Gilford progeria
☐ Limb girdle muscular dystrophy
☐ Mandibulo-acral dysplasia
☐ Restrictive Dermopathy
☐ Other: _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply and describe)

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

Has the patient undergone previous DNA testing for a laminopathy? ☐ No ☐ Yes ☐ Unknown

If yes, describe the genes, disorder, methodology, and results: _____

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset: _____

Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Check the test you intend to order.

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

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; a copy of the relative's lab result is REQUIRED

Master Label

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