ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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

500 Chipeta Way
Salt Lake City, Utah 84108-1221
phone: (801) 583-2787 | toll free: (800) 242-2787
fax: (801) 584-5249 | www.aruplab.com

THIS IS NOT A TEST REQUEST FORM.
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 Name _____ **Date of Birth** _____ **Sex** ☐ F ☐ M

Physician _____ **Physician Phone** _____

Practice Specialty _____ **Physician Fax** _____

Genetic Counselor _____ **Counselor Phone** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Clinical Diagnosis:

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

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

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

☐ **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 mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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