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.

PATIENT HISTORY FOR STICKLER SYNDROME TESTING

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

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

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

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

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

- Ocular
  - ☐ Retinal Detachment
  - ☐ Cataract
  - ☐ Myopia
  - ☐ Vitreous abnormalities (describe: _____)
  - ☐ Other (describe: _____)
- Hearing Loss
  - ☐ Conductive ☐ Sensorineural ☐ Mixed
  - ☐ Unilateral ☐ Bilateral
- Craniofacial
  - ☐ Midface hypoplasia
  - ☐ Micrognathia/retrognathia
  - ☐ Cleft lip/palate (describe: _____)
- Skeletal
  - ☐ Arthritis (age of onset: _____)
  - ☐ Scoliosis/kyphosis
  - ☐ Spondyloepiphyseal dysplasia
  - ☐ Short stature (Height: _____)
  - ☐ Other (describe: _____)

☐ Other symptom(s): _____

Has the patient undergone any previous DNA testing? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) 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.

☐ **3001613 Stickler Syndrome Panel, Sequencing:**
Tests for common genes associated with Stickler syndrome and related disorders.

☐ **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.