

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 Assigned at Birth: Female Male Intersex **Gender Identity (optional):** Female Male _____
Ordering Provider: _____ **Provider's Phone:** _____
Practice Specialty: _____ **Provider's Fax:** _____
Genetic Counselor: _____ **Counselor's 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 variant testing).



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