ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR DUCHENNE/BECKER MUSCULAR DYSTROPHY GENETIC 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 _____

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

☐ Calf hypertrophy
☐ Cardiomyopathy
☐ Difficulty walking/abnormal gait
☐ Flexion contracture of the elbows
☐ Generalized motor delay
☐ Gower sign
☐ Intellectual disability
☐ Myalgia/muscle cramping
☐ Muscle weakness
Age of onset: _____
☐ Wheelchair dependent
☐ Other _____

Laboratory Findings

Serum creatine phosphokinase (CK):	☐ Abnormal _____U/L	☐ Normal	☐ Not performed
Muscle histology:	☐ Abnormal _____	☐ Normal	☐ Not performed
Dystrophin immunohistochemistry:	☐ Abnormal _____	☐ Normal	☐ Not performed
Dystrophin quantity:	☐ Abnormal _____ %	☐ Normal	☐ Not performed

Has the patient undergone previous DNA testing for muscular dystrophy/cardiomyopathy? ☐ No ☐ Yes ☐ Unknown

If yes, describe test(s) and results: _____

_____

Is there any relevant family history of muscular dystrophy? ☐ No ☐ Yes ☐ Unknown

If yes, specify: ☐ Duchenne muscular dystrophy ☐ Becker muscular dystrophy ☐ Dilated cardiomyopathy

Attach a pedigree or specify the relationship of family member(s) to the patient: _____

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

The relative is: ☐ a carrier ☐ affected

If affected, list the symptoms and age of onset: _____

_____

Attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing.)

Check the test you intend to order.

Recommended testing for Duchenne/Becker muscular dystrophy if there is no known familial variant:

☐ **2011241 Duchenne/Becker Muscular Dystrophy (*DMD*) Deletion/Duplication with Reflex to Sequencing**
☐ **2011235 Duchenne/Becker Muscular Dystrophy (*DMD*) Deletion/Duplication**
☐ **2011153 Duchenne/Becker Muscular Dystrophy (*DMD*) Sequencing**

Follow-up targeted testing for known mutation in family members:

☐ **2011235 Duchenne/Becker Muscular Dystrophy (*DMD*) Deletion/Duplication** Tests for a deletion/duplication previously identified in a family member; a copy of relative's lab result is REQUIRED.

☐ **2001961 Familial Mutation, Targeted Sequencing** Tests for sequence variant 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