ARUP LABORATORIES

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

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

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

DUCHENNE/BECKER MUSCULAR DYSTROPHY GENETIC TESTING PATIENT HISTORY FORM

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)

☐ Calf hypertrophy ☐ Generalized motor delay ☐ Muscle weakness

☐ Cardiomyopathy ☐ Gower sign Age of onset: _____

☐ Difficulty walking/abnormal gait ☐ Intellectual disability ☐ Wheelchair dependent

☐ Flexion contracture of the elbows ☐ Myalgia/muscle cramping

☐ 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 variant testing.)

Master Label

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