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.

ALPORT SYNDROME 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 of Alport syndrome? ..... ☐ No ☐ Yes (check all that apply and describe)

Renal Findings:

- ☐ Hematuria
- ☐ Proteinuria
- ☐ Renal insufficiency
- ☐ End-stage renal failure (age of onset: _____)

Ocular Findings:

- ☐ Anterior lenticonus
- ☐ Cataracts
- ☐ Corneal vesicles or erosion
- ☐ Maculopathy

Auricular finding:

- ☐ Sensorineural hearing loss (age of onset: _____)

Smooth muscle tumors:

- ☐ Leiomyomatosis

☐ **Other symptoms(s):** _____

Has the patient undergone previous germline DNA testing for Alport syndrome? ..... ☐ No ☐ Yes ☐ Unknown

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

Is there any family history of Alport syndrome? ..... ☐ 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

Master Label