

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

ARTHROGRYPOSIS PANEL 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 Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)
 African American/Black Asian Hispanic White Other: _____

List country of origin (if known): _____

Suspected diagnosis:
 Distal arthrogryposis Multiple congenital contractures Fetal akinesia Amyoplasia
 Other: _____

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

<input type="checkbox"/> Decreased fetal movement	<input type="checkbox"/> Hypotonia
<input type="checkbox"/> Contractures (location): _____	<input type="checkbox"/> Pterygium (webbing) of joints
<input type="checkbox"/> Dimples near joints with contractures	<input type="checkbox"/> Seizures
<input type="checkbox"/> Abnormal position of hands/feet	<input type="checkbox"/> Maternal conditions (please specify): _____
<input type="checkbox"/> Polyhydramnios	_____
<input type="checkbox"/> IUGR	<input type="checkbox"/> In utero infection (please specify): _____
<input type="checkbox"/> Lung hypoplasia	_____
<input type="checkbox"/> Developmental delay/intellectual disability	<input type="checkbox"/> Other: _____
<input type="checkbox"/> CNS anomalies	_____

Does the patient have any radiographic findings?..... No Yes (describe details below) Unknown

Has the patient undergone previous DNA testing for arthrogryposis?..... No Yes Unknown

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

Is there any relevant family history of arthrogryposis? 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).

Master Label

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