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.

PATIENT HISTORY FOR EMERY-DREIFUSS MUSCULAR DYSTROPHY (EDMD) TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male
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 clinical findings of EDMD? ☐ No ☐ Yes (check all that apply and describe) ☐ Unknown

☐ Joint contractures (age of onset: _____)
- ☐ Elbow flexors ☐ Achilles tendon ☐ Neck/spine ☐ Other: _____

☐ Muscle wasting or weakness (age of onset: _____)
- ☐ Humeroperoneal ☐ Scapular ☐ Pelvic girdle ☐ Other: _____

☐ Cardiac disease
- ☐ Conduction defect/arrhythmia (describe: _____)
- ☐ Dilated cardiomyopathy ☐ Hypertrophic cardiomyopathy ☐ Other: _____

☐ EMG findings: _____

☐ Other: _____

Laboratory Findings

☐ Serum CK..... ☐ Abnormal (_____U/L) ☐ Normal ☐ Not performed
☐ Muscle histopathology..... ☐ Abnormal (describe: _____) ☐ Normal ☐ Not performed
☐ Immunodetection ..... ☐ Abnormal (describe: _____) ☐ Normal ☐ Not performed

Has the patient undergone previous germline DNA testing for muscular dystrophy? ..... ☐ No ☐ Yes ☐ Unknown

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

_____

Is there any relevant family history of EDMD?..... ☐ 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.