

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

PATIENT HISTORY FOR TAY-SACHS DISEASE (HEXA DEFICIENCY) TESTING

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 Ashkenazi Jewish Asian French Canadian
 Hispanic White Other: _____

List country of origin (if known): _____

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

- Ataxia Developmental delay Loss of motor skills
 Blindness Hypotonia Seizures
 Cherry-red spot on macula Liver disease Spasticity
 Neurodegeneration (describe): _____
 Other symptom(s): _____

Laboratory Findings:

HEX A enzyme (serum) Normal Abnormal (result: _____) Not performed Unknown
HEX A enzyme (leukocytes) Normal Abnormal (result: _____) Not performed Unknown

Has the patient undergone previous DNA testing for Tay-Sachs Disease? No Yes Unknown

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

Is there any relevant family history of Tay-Sachs disease? 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 for the HEXA 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).

Is the patient's reproductive partner a carrier of Tay-Sachs disease? No Yes Unknown

If yes, please list the variant _____



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