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.

CHARCOT-MARIE-TOOTH (CMT) AND HEREDITARY NEUROPATHY 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): _____

Suspected Diagnosis; Age of Onset**:** _____

☐ Charcot-Marie-Tooth disease (CMT); type: _____ ☐ Hereditary sensory neuropathy (HSN)

☐ Hereditary motor neuropathy (HMN) ☐ Transthyretin amyloidosis

☐ Hereditary neuropathy with liability to pressure palsies (HNPP) ☐ Other: _____

Does the patient have symptoms of CMT/hereditary neuropathy? ..... ☐ No ☐ Yes (check all that apply)

☐ Abnormal gait/difficulty walking	☐ Spastic paraplegia		
☐ Abnormal reflexes	☐ Muscle wasting; (specify).....	☐ proximal	☐ distal
☐ Carpal tunnel syndrome	☐ Muscle weakness; (specify).....	☐ progressive	☐ stable
☐ Foot drop	.....	☐ proximal	☐ distal
☐ Hearing loss	☐ Peripheral neuropathy; (specify).....	☐ sensory	☐ motor
☐ High arches/pes cavus deformity	☐ Transient/recurring focal pressure neuropathy		
☐ Hip dysplasia	☐ Other: _____		

Diagnostic Studies:

☐ Electromyography (EMG): ☐ Normal ☐ Abnormal—describe: _____

☐ Nerve conduction velocity (NCV): ☐ Normal ☐ Demyelinating (<38 m/s) ☐ Axonal (>38 m/s) ☐ Intermediate (25–45 m/s)

☐ Other: _____

Has the patient undergone previous DNA testing for CMT/hereditary neuropathy? ..... ☐ No ☐ Yes ☐ Unknown

☐ *PMP22* deletion/duplication; result: _____

☐ Chromosomal microarray; result: _____

☐ Other testing; describe test(s) and results: _____

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