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.

CARDIOMYOPATHY/ARRHYTHMIA GENETIC 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): _____

Clinical Diagnosis (Age at Diagnosis:_____)

☐ ARVC ☐ CPVT ☐ HCM ☐ LVNC ☐ SQTS
☐ Brugada syndrome ☐ DCM ☐ LQTS ☐ RCM ☐ Unknown
☐ Other: _____

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

☐ Syncope ☐ Cardiac arrest ☐ Hypertension ☐ Other: _____

Tests Performed (check all that apply)

☐ Electrocardiogram (ECG) ☐ Normal ☐ Abnormal ☐ Not Performed ☐ Unknown
☐ Echocardiogram (ECHO) ☐ Normal ☐ Abnormal ☐ Not Performed ☐ Unknown
☐ Cardiac MRI ☐ Normal ☐ Abnormal ☐ Not Performed ☐ Unknown
☐ Other: _____

Cardiac Findings

☐ Ventricular hypertrophy ☐ LV ☐ RV max wall thickness:_____mm
☐ Ventricular enlargement/dilation ☐ Left ☐ Right
☐ Ejection fraction ☐ Normal ☐ Preserved ☐ Reduced:_____% ☐ Increased: _____%
☐ Arrhythmia/conduction disease ☐ AV block ☐ AFib ☐ VT ☐ WPW ☐ Other: _____
☐ Fatty infiltration
☐ Other: _____

Devices ☐ Pacemaker ☐ Implantable Cardioverter Defibrillator (ICD) ☐ Left Ventricular Assist Device (LVAD)

Has the patient undergone previous DNA testing?.....☐ No ☐ Yes ☐ Unknown
If yes, describe the genes, disorder, methodology, and results: _____

Is there any relevant family history of cardiomyopathy/arrhythmia/sudden death?.....☐ 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