

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: 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): _____

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

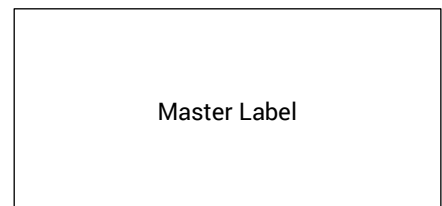
If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset: _____

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 mutation testing). _____

Check the test you intend to order.

- 2010183 Cardiomyopathy and Arrhythmia Panel, Sequencing and Deletion/Duplication**
- 3001581 Dilated Cardiomyopathy Panel, Sequencing**
- 3001579 Hypertrophic Cardiomyopathy Panel, Sequencing**
- 3001603 Long QT Panel, Sequencing and Deletion/Duplication**
- 2001961 Familial Mutation, Targeted Sequencing.** Tests for a specific sequence change previously identified in a family member.
A copy of a relative's DNA laboratory result is REQUIRED.



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