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.

CARDIOMYPATHY/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.

Master Label

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