ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR CARDIOMYOPATHY/ARRHYTHMIA GENETIC TESTING

Patient Name _____ **Date of Birth** _____ **Sex** ☐ F ☐ M

Physician _____ **Physician Phone** _____

Practice Specialty _____ **Physician Fax** _____

Genetic Counselor _____ **Counselor Phone** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

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? ☐ 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**

☐ **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