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.

SPINAL MUSCULAR ATROPHY (SMA) TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐ Female ☐ Male

Indication for Testing/Reason for Referral:

☐ Routine preconception or prenatal carrier screening

☐ Symptoms (check all that apply)

- ☐ Abnormal reflexes
- ☐ Abnormal test results (EMG, NCV, histology, etc.); describe: _____
- ☐ Abnormal ultrasound findings; describe: _____
- ☐ Arthrogryposis
- ☐ Finger tremor
- ☐ Hypotonia
- ☐ Lack of motor development
- ☐ Muscle weakness
- ☐ Respiratory distress
- ☐ Tongue fasciculations
- ☐ Other symptom(s): _____

For questions, contact ARUP Client Services at 800-522-2787

Master Label