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 FAMILIAL TRANSTHRYRETIN (TTR) AMYLOIDOSIS

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 ☐ Caucasian ☐ Japanese ☐ Portuguese
☐ Ashkenazi Jewish ☐ Hispanic ☐ Middle Eastern ☐ Other: _____

Does the patient have symptoms of any of the following TTR phenotypes? ☐ No ☐ Yes (check all that apply)

☐ TTR amyloid polyneuropathy ☐ TTR leptomeningeal amyloidosis
☐ TTR cardiac amyloidosis ☐ TTR oculoleptomeningeal amyloidosis
☐ Other: _____

Does the patient have symptoms of TTR amyloidosis? ☐ No ☐ Yes (check all that apply)

☐ Peripheral sensory/motor neuropathy
- ☐ Loss of sensation in feet or hands
- ☐ Prickling/burning/numbness in extremities
- ☐ Muscle weakness
- ☐ Difficulty walking or using arms/hands

☐ Autonomic neuropathy
- ☐ Sweating too much or too little
- ☐ Vomiting/delayed gastric emptying
- ☐ Constipation/diarrhea
- ☐ Sexual impotence
- ☐ Orthostatic fainting
- ☐ Urinary incontinence or retention

☐ Nephropathy

☐ Vitreous opacities

☐ CNS findings
- ☐ Visual impairment
- ☐ Dementia
- ☐ Ataxia/spasticity
- ☐ Seizures
- ☐ Psychosis
- ☐ Hydrocephalus

☐ Cardiac Disease
- ☐ Cardiomegaly
- ☐ Conduction block
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Aortic dissection/dilatation

☐ Other symptom(s): _____

Other laboratory testing for TTR amyloidosis: ☐ Not performed ☐ Performed (describe below) ☐ Unknown

☐ Congo red staining/immunohistochemistry.... ☐ Normal ☐ Abnormal: _____ ☐ Uncertain: _____
☐ Serum TTR testing by mass spec ..... ☐ Normal ☐ Abnormal: _____ ☐ Uncertain: _____

Is there any relevant family history? ☐ 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.

Recommended first tier testing for ATTR:

☐ **2014035 Familial Transthyretin Amyloidosis (TTR) Sequencing:** Detects>99% of mutations causative for TTR amyloidosis.

Targeted testing for known mutation (A copy of a relative's lab result is REQUIRED):

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member.

Master Label

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