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.

FAMILIAL TRANSTHYRETIN (TTR) AMYLOIDOSIS PATIENT HISTORY

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): _____

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

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

Does the patient have <u>symptoms</u> 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/dilation

☐ Other symptom(s): _____

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

☐ Congo red staining/immunochemistry ☐ Normal ☐ Abnormal: _____ ☐ Uncertain: _____

☐ Serum TTR testing by mass spec ☐ Normal ☐ Abnormal: _____ ☐ Uncertain: _____

Is there any relevant <u>family history</u>?..... ☐ No ☐ Yes ☐ Unknown

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

_____

_____

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.

<u>Recommended first-tier testing for ATTR</u>:

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

<u>Targeted testing for known mutation (a copy of a relative's lab result is REQUIRED):</u>

☐ **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.