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 WILSON DISEASE (*ATP7B*) 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: _____

**Does the patient have symptoms?** ☐ No ☐ Yes (check all that apply)

☐ Liver disease:
- ☐ Cirrhosis
- ☐ Hepatomegaly
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver failure

☐ Neurological findings:
- ☐ Abnormal movements
- ☐ Difficulty with motor tasks
- ☐ Rigidity

☐ Kayser-Fleischer rings

☐ Psychiatric disease:
- ☐ Anxiety/depression
- ☐ Cognitive/memory problems
- ☐ Personality/behavioral changes

☐ Other symptom(s): _____

**Laboratory Findings:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Serum ceruloplasmin concentration ..... | ☐ Low | ☐ High | ☐ Normal | Value:_____ mg/dL | ☐ Unknown | ☐ Not Performed |
| Serum copper concentration..... | ☐ Low | ☐ High | ☐ Normal | Value:_____ ug/dL | ☐ Unknown | ☐ Not Performed |
| Free (direct) copper concentration ..... | ☐ Low | ☐ High | ☐ Normal | Value:_____ ug/dL | ☐ Unknown | ☐ Not Performed |
| 24-hour urine copper concentration..... | ☐ Low | ☐ High | ☐ Normal | Value:_____ ug/24hrs | ☐ Unknown | ☐ Not Performed |
| Hepatic copper concentration..... | ☐ Low | ☐ High | ☐ Normal | Value:_____ ug/g | ☐ Unknown | ☐ Not Performed |

**Has the patient undergone previous DNA testing?** ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

_____

**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 Wilson disease:

☐ **2010716 Wilson Disease (*ATP7B*) Sequencing:**
Detects 98% of mutations causing Wilson disease.

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.

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

Master Label