

**THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.**

**WILSON DISEASE (ATP7B) TESTING PATIENT HISTORY FORM**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Sex Assigned at Birth:**  Female  Male  Intersex **Gender Identity (optional):**  Female  Male  \_\_\_\_\_

**Ordering Provider:** \_\_\_\_\_ **Provider's Phone:** \_\_\_\_\_

**Practice Specialty:** \_\_\_\_\_ **Provider's Fax:** \_\_\_\_\_

**Genetic Counselor:** \_\_\_\_\_ **Counselor's 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?**  No  Yes (check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Liver disease: | <input type="checkbox"/> Neurological findings:      | <input type="checkbox"/> Psychiatric disease:           |
| <input type="checkbox"/> Cirrhosis      | <input type="checkbox"/> Abnormal movements          | <input type="checkbox"/> Anxiety/depression             |
| <input type="checkbox"/> Hepatomegaly   | <input type="checkbox"/> Difficulty with motor tasks | <input type="checkbox"/> Cognitive/memory problems      |
| <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Rigidity                    | <input type="checkbox"/> Personality/behavioral changes |
| <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Kayser-Fleischer rings      | <input type="checkbox"/> Other symptom(s): _____        |
| <input type="checkbox"/> Liver failure  |  | _____   |

**Laboratory Findings:**

Serum ceruloplasmin concentration	<input type="checkbox"/> Low <input type="checkbox"/> High <input type="checkbox"/> Normal	Value: mg/dL	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Performed
Serum copper concentration	<input type="checkbox"/> Low <input type="checkbox"/> High <input type="checkbox"/> Normal	Value: ug/dL	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Performed
Free (direct) copper concentration	<input type="checkbox"/> Low <input type="checkbox"/> High <input type="checkbox"/> Normal	Value: ug/dL	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Performed
24-hour urine copper concentration	<input type="checkbox"/> Low <input type="checkbox"/> High <input type="checkbox"/> Normal	Value: ug/24hrs	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Performed
Hepatic copper concentration	<input type="checkbox"/> Low <input type="checkbox"/> High <input type="checkbox"/> Normal	Value: ug/g	<input type="checkbox"/> Unknown	<input type="checkbox"/> 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 variant testing). \_\_\_\_\_



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