

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform Angelman Syndrome DNA testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR ANGELMAN SYNDROME DNA TESTING

Patient's Name _____ **Date of Birth** ____/____/____ **Gender** [] F [] M

Physician _____ **Physician Phone** (____) _____ **Practice Specialty** _____

Genetic Counselor _____ **Counselor Phone** (____) _____

Patient's Ethnicity (check all that apply)

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Does the patient have SYMPTOMS? [] No [] Yes, check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Normal head circumference at birth | <input type="checkbox"/> Excitability | <input type="checkbox"/> Tongue thrusting; feeding problems |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Hand flapping | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Minimal or absent speech | <input type="checkbox"/> Microcephaly | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Gait ataxia and/or tremor of limbs | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Abnormal EEG | <input type="checkbox"/> Strabismus | |
| <input type="checkbox"/> Inappropriate happy demeanor | <input type="checkbox"/> Sleep disturbance | |

Has the patient undergone previous DNA testing for Angelman syndrome? [] No [] Yes [] Unknown

- | | |
|---|--------------|
| <input type="checkbox"/> DNA methylation analysis | Result _____ |
| <input type="checkbox"/> FISH analysis | Result _____ |
| <input type="checkbox"/> Array CGH | Result _____ |
| <input type="checkbox"/> UPD testing | Result _____ |
| <input type="checkbox"/> Imprinting center defect testing | Result _____ |

Does the patient have a FAMILY History of Severe developmental delay/MR/Angelman syndrome?

- [] Yes [] No [] Unknown

If yes, please attach a **PEDIGREE** or specify the **RELATIONSHIP** of the family member(s) to the patient and detail the symptoms in each symptomatic/affected relative _____

Has DNA testing been performed for these family member(s)? [] Yes [] No [] Unknown

If yes, please attach a copy of the relative's DNA laboratory result (**REQUIRED** for familial mutation testing).

Circle the test you intend to order.

2005077 Angelman Syndrome and Prader-Willi Syndrome by Methylation: The most sensitive test to confirm a diagnosis of Angelman syndrome and Prader-Willi syndrome; clinical sensitivity is approximately 78% for Angelman syndrome and 99% for Prader-Willi syndrome.

2005564 Angelman Syndrome (UBE3A) Sequencing: To confirm a diagnosis of Angelman syndrome in individuals with a normal DNA methylation test; clinical sensitivity is approximately 11%.

2001961 Familial Mutation, Targeted Sequencing: Tests for a previously identified familial mutation; copy of a relative's lab result is **REQUIRED**.

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

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