

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

PATIENT HISTORY FOR FREEMAN-SHELDON SYNDROME TESTING

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

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

Genetic Counselor _____ **Counselor's 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"/> Small pinched mouth | <input type="checkbox"/> Dental crowding |
| <input type="checkbox"/> H-shaped dimpling of the chin | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Ulnar deviation of the wrists and fingers | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Camptodactyly | <input type="checkbox"/> Congenital hearing loss |
| <input type="checkbox"/> Clubfoot | <input type="checkbox"/> Inguinal hernia |
| <input type="checkbox"/> Underdeveloped/absent flexion creases of the hands | <input type="checkbox"/> Cryptorchidism |
| <input type="checkbox"/> Hips/elbow contractures | <input type="checkbox"/> Other _____ |

Does the patient have a FAMILY HISTORY of **Freeman-Sheldon Syndrome** Contractures
 Neither Unknown

If yes, please attach PEDIGREE or specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic relative.

Has the patient undergone previous testing for Freeman-Sheldon syndrome? No Yes
If yes, please describe test(s) and results

Freeman-Sheldon Syndrome Testing

2002662 Freeman-Sheldon Syndrome (MYH3) Sequencing Exon 17

Offer to patients who have multiple joint and facial contractures. Clinical sensitivity approximately 70%.

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

Master Label