

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

PATIENT HISTORY FOR LAMINOPATHIES (LMNA) GENE 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 _____ |

PATIENT'S CLINICAL DIAGNOSIS

- | | | |
|--|--|---|
| <input type="checkbox"/> Hutchinson-Gilford Progeria | <input type="checkbox"/> Emery-Dreifuss Muscular Dystrophy | <input type="checkbox"/> Limb Girdle Muscular Dystrophy |
| <input type="checkbox"/> Charcot-Marie-Tooth | <input type="checkbox"/> Familial Partial Lipodystrophy | <input type="checkbox"/> Dilated Cardiomyopathy |
| <input type="checkbox"/> Mandibulo-Acral Dysplasia | <input type="checkbox"/> Atypical Werner Syndrome | <input type="checkbox"/> Restrictive Dermopathy |
| <input type="checkbox"/> Other _____ | | |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Premature aging | <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Growth retardation |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Hypogonadism | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Joint degeneration | <input type="checkbox"/> Joint contractures | <input type="checkbox"/> Fetal akinesia |
| <input type="checkbox"/> Progressive muscle weakness/wasting | <input type="checkbox"/> Distal muscle weakness | <input type="checkbox"/> Absent tendon reflexes |
| <input type="checkbox"/> Cardiac conduction defects | <input type="checkbox"/> Impaired systolic function | <input type="checkbox"/> Progressive ventricular dilation |
| <input type="checkbox"/> Excess fat on face/neck | <input type="checkbox"/> Loss of subcutaneous fat from extremities | |
| <input type="checkbox"/> Mottled cutaneous pigmentation | <input type="checkbox"/> Craniofacial and skeletal anomalies, specify: _____ | |
| <input type="checkbox"/> Other: _____ | | |

Does the patient have a FAMILY HISTORY of any of the above symptoms? No Yes Unknown

If yes, attach a 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 DNA testing been performed for these family member(s)? No Yes Unknown

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

Has the patient undergone previous DNA testing for a Laminopathy? No Yes Unknown

If yes, please describe the gene/disorder, methodology, and results _____

Circle the test you intend to order.

2004543 LMNA-Related Disorders (LMNA) Sequencing

Sequence analysis of LMNA coding regions; clinical sensitivity is dependent upon the specific LMNA-related disorder.

2004539 LMNA-Related Disorders (LMNA) Deletion/Duplication

For patients with clinical features of non-X linked EDMD2, LGMD1B, or inherited DCM and negative LMNA sequencing result, clinical sensitivity varies with specific LMNA-related disorder. **Also order for familial LMNA large deletion or duplication testing.**

2001961 Familial Mutation, Targeted Sequencing

Tests for a LMNA sequence change identified in a family member; copy of relative's lab result is REQUIRED.

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

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