ARUP LABORATORIES

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

PATIENT HISTORY FOR HYPERTROPHIC CARDIOMYOPATHY (HCM) TESTING

Patient's Name _____Date of Birth _____

Ethnicity_____ Gender [ ] Female [ ] Male

Physician _____ Physician Phone (_____) _____ Practice Specialty _____

Genetic Counselor _____ Counselor Phone (_____)_____

CLINICAL FINDINGS (check all that apply)
[ ] None
[ ] Left Ventricular Hypertrophy (LVH) Max wall thickness _____mm If yes, [ ] Asymmetric [ ] Concentric
[ ] Ventricular Enlargement/Dilation If yes, [ ] Left [ ] Right
[ ] Left Ventricular Non-Compaction (LVNC)
[ ] Reduced Ejection Fraction _____%
[ ] Conduction Disease/Arrhythmia If yes, [ ] Wolff-Parkinson-White [ ] AV Block [ ] Ventricular Tachycardia [ ] Atrial Fibrillation
[ ] Fabry Disease (describe_____)
[ ] Danon Disease (describe features_____)
[ ] Barth Syndrome (describe features_____)
[ ] TTR Amyloidosis (describe features_____
[ ] Myocardial Infarction
[ ] Syncope
[ ] Hypertension
[ ] Other _____

Age at Diagnosis _____

TESTS PERFORMED (check all that apply)

Electrocardiogram (ECG)	[ ] Normal	[ ] Abnormal	[ ] Not performed
Echocardiogram (ECHO)	[ ] Normal	[ ] Abnormal	[ ] Not performed
Cardiac MRI	[ ] Normal	[ ] Abnormal	[ ] Not performed

Other: _____

DEVICES
[ ] Pacemaker Age at procedure_____
[ ] Implantable Cardioverter Defibrillator (ICD) Age at procedure_____

FAMILY HISTORY
[ ] None [ ] Unknown [ ] HCM [ ] DCM [ ] ARVC [ ] LVNC [ ] Sudden death [ ] Other_____
If yes, what is the specific **RELATIONSHIP** of the family member(s) to the patient? _____

Has DNA testing for HCM been performed for these family member(s)? [ ] Yes [ ] No [ ] Unknown
If yes, **GENE and MUTATION** identified in the family _____

Circle the HYPERTROPHIC CARDIOMYOPATHY TEST you intend to order.

2006265 Hypertrophic Cardiomyopathy (HCM) Panel, 18 Genes

0093482 Hypertrophic Cardiomyopathy, Familial Mutation

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

Master Label