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

SPINAL MUSCULAR ATROPHY (SMA) TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Biological Sex: Female Male

Indication for Testing/Reason for Referral:

- Routine preconception or prenatal carrier screening
- Symptoms (check all that apply)
 - Abnormal reflexes
 - Abnormal test results (EMG, NCV, histology, etc.); describe: _____
 - Abnormal ultrasound findings; describe: _____
 - Arthrogryposis
 - Finger tremor
 - Hypotonia
 - Lack of motor development
 - Muscle weakness
 - Respiratory distress
 - Tongue fasciculations
 - Other symptom(s): _____

For questions, contact ARUP Client Services at 800-522-2787

Master Label