Cleveland Clinic
Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

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

PATIENT HISTORY FOR CREATINE DEFICIENCY SYNDROMES TESTING

PATIENT INFORMATION

Patient's Last Name: ________________________ First Name: ____________________ MI: ________

Birth Date: ______________________________ Gender: ❑ Male ❑ Female

Referring Physician (last, first): ____

Referring Physician Phone: (________) ____________________ Practice Specialty: ______________________

Genetic Counselor (last, first): ____

Genetic Counselor Phone: (________) ____________________

PATIENT'S ETHNICITY (check all that apply)

❑ African American ❑ Asian ❑ Hispanic ❑ Native American
❑ Ashkenazi Jewish ❑ Caucasian ❑ Middle Eastern ❑ Other ________________

DOES THE PATIENT HAVE SYMPTOMS OF A CREATINE DEFICIENCY SYNDROME? ❑ No ❑ Yes ❑ Unknown

If Yes, check all that apply:

❑ Intellectual disability ❑ Autistic behaviors ❑ Speech/Language delay ❑ Other ________________
❑ Movement disorder ❑ Self injury ❑ Seizures

LABORATORY FINDINGS

Brain creatine level (by MRS)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Guanidinoacetate (plasma)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Guanidinoacetate (urine)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Creatine (plasma)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Creatine (urine)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Creatine:creatinine ratio (urine)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown
Creatine transport (fibroblasts)	❑ Normal	❑ Low	❑ High	❑ Not performed	❑ Unknown

FAMILY HISTORY OF ANY OF THE ABOVE SYMPTOMS? ❑ No ❑ Yes ❑ Unknown

If Yes, please specify the relationship of the family member(s) to the patient and describe the symptoms in each symptomatic relative:

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Has DNA testing for creatine deficiency syndromes been performed for these family members? ❑ No ❑ Yes ❑ Unknown

If Yes, please attach a copy of the laboratory result (REQUIRED for familial mutation testing).

DESCRIPTION OF CREATINE DEFICIENCY SYNDROMES TESTING

❑ **UGUANI** **Creatine Disorders Panel, Urine:** Order as initial test with plasma in individuals with symptoms or abnormal MRS.

❑ **GUANID** **Creatine Disorders Panel, Blood:** Order as initial test with urine panel in individuals with symptoms or abnormal MRS.