Cleveland Clinic
Laboratories

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Cleveland, OH 44106
216.444.5755 or 800.628.6816

THIS IS NOT A TEST REQUEST FORM. PLEASE COMPLETE AND SUBMIT WITH THE TEST REQUEST FORM OR ELECTRONIC PACKING LIST.

MUCOPOLYSACCHARIDOSIS (MPS) TESTING PATIENT HISTORY FORM

PLEASE PRINT

Patient's Name: ____________________

Date of Birth: ______ / ______ / ________ Sex assigned at birth: ❑ Female ❑ Male ❑ Intersex

Gender identity (optional): ❑ Female ❑ Male ❑ ____________

Ordering provider: ____________________ Provider's Phone: (______) __________

Practice specialty: ____________________ Provider's Fax: (______) __________

Genetic counselor: ____________________ Counselor's Phone: (______) __________

Reason for testing:

❑ Diagnostic: ____________ ❑ Monitoring for: ____________

❑ Abnormal newborn screen for: ____________ ❑ Other: ____________

Previous testing:

❑ Enzyme testing results: ____________________ ❑ N/A

❑ Genetic testing results: ____________________ ❑ N/A

Symptoms (please attach clinical notes if available): ❑ No ❑ Yes (check all that apply and describe)

❑ Cardiomyopathy ❑ Coarse features ❑ Corneal clouding ❑ Developmental delay

❑ Organomegaly ❑ Short stature ❑ Skeletal anomalies ❑ Macrocephaly

❑ Other symptom(s): ____________________

Is the patient currently on **enzyme replacement therapy**? ❑ No ❑ Yes: ____________

Other medications/treatments: ____________________

Has the patient received **stem cell transplantation**? ❑ No ❑ Yes If yes, date of transplant: ____________

Family history (please attach pedigree):

Other similarly affected family members? ____________________