LabCorp
Laboratory Corporation of America

Clinical Questionnaire for MECP2-related Disorders

This form should be completed when DNA testing for MECP2-related disorders is ordered. This form should be completed by the ordering physician's office and should accompany the sample. Please call 800-345-4363 (800-345-GENE) with any questions.

Patient's name: _____

Date of birth: _____ Gender: ◯ M ◯ F

Name of person completing form: _____

Physician's name: _____

Physician's signature _____

Physician signature is requires on printed from

Indications for Testing

Patient Ethnicity

◯ Caucasian ◯ Asian ◯ Native American/American Indian ◯ Unknown

◯ Hispanic ◯ Ashkenazi Jewish ◯ African American/Black ◯ Other (specify) _____

Patient History

Height _____ cm Weight _____ kg

Head circumference _____ cm Deceleration of head growth (>6 mo) ◯ Yes ◯ No

Clinical Phenotype (please check as appropriate):

Age at onset of regression: ◯ <6 mo ◯ 6-18 mo ◯ >18 mo

Speech: ◯ Normal speech ◯ Delayed speech ◯ No speech

Age at sitting: ◯ Sits alone (<8 mo) ◯ Sits alone (>8 mo) ◯ Never sits alone independently

Walking skills: ◯ Normal ◯ With difficulty ◯ Never walked or lost ability to walk

Language: ◯ Some language ◯ Vocalization, babbling ◯ Screaming, no utterance

Stereotypic hand movement: ◯ Never ◯ 25% to 50% of time ◯ 75% to 90% of time

History of epilepsy: ◯ Never ◯ Occasional seizures ◯ Continuing epilepsy

Breathing: ◯ Normal ◯ Abnormal

Scoliosis: ◯ No scoliosis ◯ Scoliosis ◯ Scoliosis operated

Comments:

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