Genetic Mutation Worksheet

Information regarding your patient's genetic testing

Fax completed form, along with the patient's START form, to 1-800-621-5203

Please use this worksheet as a guide to understand whether your patient is appropriate for therapy.

What is the date of last genetic test performed for this patient?

Month _____ Year _____ ☐ Do not know ☐ This patient has never had a genetic test

Please note: If your patient does not have a genetic test, please obtain one and then complete this form.

What is the name of the lab that performed the genetic test for this patient?

Name _____

Please note: Some managed care organizations might request a copy of the genetic test to get started on a therapy in a timely manner. Please provide a copy, if available.

Based on the results of the genetic test, what type of mutation (or genotype) does this patient have? *(Please select only one)*

☐ Deletion ☐ Duplication ☐ Point mutation ☐ None of the above ☐ Do not know

Where is the location of this patient's deletion(s) on the gene?

Single deletion, located at exon _____

Example: exon 50

Deletion range, located at (enter first and last missing exons; enter as many ranges as necessary):

exon_____ to exon_____

exon_____ to exon_____

exon_____ to exon_____

Examples:
exon 45 to exon 50
exon 48 to exon 50 and exon 52

Which exon skip is your patient amenable to?

☐ Exon 51 ☐ Exon 53 ☐ Exon 45 ☐ Exon 44 ☐ Exon 50 ☐ Exon 52 ☐ Exon 55

If you have any additional comments about this patient's exon deletion, you may enter this information below.

_____

_____

Physician Information

First Name:		Last Name:	
Center Name:		Address:	
City:	State:	ZIP:	Phone Number:

Signature: _____

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Please contact us with any questions
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