LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for **Calcium-Sensing Receptor (*CASR*) Gene Sequencing**

This questionnaire should be completed when DNA testing for *CASR* gene sequencing is ordered. Please fax the completed form to 818-880-8541 and include the original copy if the sample is collected in the physician's office. Please call 800-444-9111 with any questions.

Patient Information

Patient's name: _____

Date of Birth: _____ **Gender:** ❍ **Male** ❍ **Female**

Name of person completing form: _____

Physician's signature: _____ **Date** _____ **/ Physician's phone** _____
Physician signature required on printed form

Indications for Testing

What is the suspected diagnosis?

❍ Familial hypocalciuric hypercalcemia (FHH)

❍ Neonatal severe hyperparathyroidism (NSHPT)

❍ Autosomal dominant hypocalcemia

❍ Bartter syndrome type V

Patient presentation of: ❍ **Hypercalcemia** ❍ **Hypocalcemia** ❍ **Other:** _____

Serum calcium level if known: _____ mg/dL

Urinary calcium: creatinine ratio (UCCR), if known: _____

Family History

Family history of : ❍ **hypercalcemia** ❍ **hypocalcemia**

Family member with known *CASR* mutation: ❍ **Yes** ❍ **No**

If yes, indicate previously reported mutation: Exon: _____ Nucleotide change: _____

List the affected family member(s) and relationship to this patient:

Family member: _____ Relationship to patient: _____

Family member: _____ Relationship to patient: _____

Family member: _____ Relationship to patient: _____

Family member: _____ Relationship to patient: _____

Family member: _____ Relationship to patient: _____

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