Universitätsklinikum Carl Gustav Carus
Klinik und Poliklinik für Neurologie, AG Mitochondriale Erkrankungen
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From:

Request for Mitochondrial Diagnostics

Patient: Sex: ☐ female ☐ male

Last Name: _____ First Name: _____ Date of Birth: _____

Address:

_____

_____

Tissue: ☐ EDTA-Blood ☐ Muscle ☐ Fibroblasts ☐ Urin Other _____

Date of Sampling: _____ Time of Sampling: _____

Desired Analysis: ☐ Molecular Genetics

Desired special Analysis: _____

_____

Suspected clinical Diagnosis: _____

_____

_____

Costs of Analysis
☐ will be met by the insurer
☐ will be met by the referring clinic
☐ will be met by the patient

_____	_____	_____	_____
Date	Doctor's Name	Doctor's Signature	Doctor's Phone Number

Clinical Information

For specific analysis we need your support. Please fill out the following list. Thank you.

Patient's Name: **Date of Birth:**

Symptoms (please mark)	
Anorexia	
Ataxia	
Breath Insufficiency	
Ocular Motor Dysfunction	
Exercise Intolerance	
CPEO	
Dementia	
Diabetes mellitus	
Depression	
Dysarthria	
Dysphagia	
Dystonia	
Epilepsy	
Floppy infant	
Gastro-intestinal Dysfunction	
Deafness	
Camptocormia	
Cataract	
Cardiomyopathye	
Short Stature	
Cognitive Impairment	
Headache	
Migraine	
Multiple Sklerosis	
Muscle Pain	
Muscle Weakness (distal)	
Muscle Weakness (proximal)	
Myoclonus	
Optic Atrophy	
Secondary Ovarian Failure	
Pancytopenia	
Parkinson	
Psychological Disturbance	
Ptosis	
Retinal Degeneration	
Rhabdomyolysis	
Stroke like episodes	
Symmetric Lipomatosis	
Tremor	
Visual Disturbance	

Diagnostic (please mark)	Normal	Positive
Acylcarnitine / Organoaciduria		
Creatine Kinase		
Lactat acid in blood		
CSF Lactate		
EMG		
Exercise Test		
Polyneuropathy		
MRT		
Muscle Biopsy		
COX-negative Fibres		
Ragged Red Fibres		
Lipid Storage		

Family History

(including neurodegenerative diseases e. g. Parkinsonism)

Muscle Biopsy

MRT

Remarks