## HOPITAL LARIBOISIERE LABORATOIRE D'HISTO-EMBRYO-CYTOGENETIQUE Prof. E. TOURNIER-LASSERVE

## INFORMATION SHEET TO BE COMPLETED WHEN REQUESTING DIAGNOSTIC TESTING FOR EPISODIC ATAXIA TYPE 2

## (Enclose a detailed hospital chart)

Patient's first name :	Last name:	
Maiden name:	4	
Date of birth:	Age:	
Clinical symptoms		
Age at clinical onset (1st attack)		
Cerebellar atrophy	yes - no	
Nystagmus:	yes - no	
Mental retardation	yes - no	
Relatives who have had episodic ataxia:	yes - no	
(surname of relatives affected if different t	o patient's)	
Other signs observed in relatives		
Treatment of the patient?		
Treatment by Acetazolamide yes - no	sensitive yes - no	
Other:		
Family Tree		