ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform hereditary paraganglioma-pheochromocytoma testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HEREDITARY PARAGANGLIOMA-PHEOCHROMOCYTOMA TESTING

Patient Name _____ **Date of Birth**_____ /_____/_____ **Gender [ ] F [ ] M**

Physician _____ **Physician Phone (_____)**_____**Practice Specialty**_____

Genetic Counselor _____ **Counselor Phone (_____)**_____

Patient's Ethnicity (check all that apply)

[ ] African-American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

Does the patient have SYMPTOMS? [ ] No [ ] Yes (check all that apply)

[ ] Pheochromocytoma ([ ] Bilateral [ ] Unilateral Age of diagnosis: _____)
[ ] Paraganglioma
  [ ] Parasympathetic (generally nonsecretory)
  [ ] Sympathetic (generally secretory)
  Location(s) and age of diagnosis: _____
[ ] Malignant paraganglioma/pheochromocytoma (Location: _____, Age of diagnosis: _____)
[ ] Renal cell carcinoma (Age of diagnosis:_____)
[ ] Breast cancer (Age of diagnosis:_____)
[ ] Papillary thyroid cancer (Age of diagnosis:_____)
[ ] Gastrointestinal stromal tumors (GISTs) (Age of diagnosis:_____)
[ ] Erythrocytosis/polycythemia (Age of diagnosis:_____)
[ ] Other_____

LABORATORY FINDINGS:

Epinephrine (adrenaline)	[ ] Abnormal	[ ] Normal	[ ] Unknown
Norepinephrine (noradrenaline)	[ ] Abnormal	[ ] Normal	[ ] Unknown
Dopamine	[ ] Abnormal	[ ] Normal	[ ] Unknown

Result by Immunohistochemistry (IHC)

[ ] Absent SDHB [ ] Normal SDHB staining [ ] Indeterminate [ ] Unknown [ ] Not performed

Does the patient have a FAMILY HISTORY? [ ] No [ ] Yes [ ] Unknown

If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family members(s) to the patient and detail the symptoms/age of onset in each symptomatic relative: _____
Has DNA testing been performed for family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, attach copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the gene/disorder, methodology, and results_____

Circle the Paraganglioma/Pheochromocytoma test you intend to order.

2007167 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*, *SDHC*, and *SDHD*) Sequencing and Deletion/Duplication
2011461 Hereditary Paraganglioma-Pheochromocytoma (*SDHA*) Sequencing
2007108 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*) Sequencing and Deletion/Duplication
2007117 Hereditary Paraganglioma-Pheochromocytoma (*SDHC*) Sequencing and Deletion/Duplication
2007122 Hereditary Paraganglioma-Pheochromocytoma (*SDHD*) Sequencing and Deletion/Duplication
2007113 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*, *SDHC*, *SDHD*) Deletion/Duplication: For patients who have had negative sequencing for one or more of the genes or if a deletion in one of these genes was previously identified in a family member, (a copy of a relative's DNA laboratory result is REQUIRED).
2001961 Familial Mutation, Targeted Sequencing: Tests for a sequence variant in previously identified in a family member. A copy of relative's DNA laboratory result is REQUIRED. Contact an ARUP genetic counselor prior to ordering.

For questions, contact a genetic counselor at (800) 242-2787, ext. 2141

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