ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR NEUROFIBROMATOSIS TYPE 1/LEGIUS SYNDROME

Patient Name _____ **Date of Birth** _____ **Sex** ☐ F ☐ M

Physician _____ **Physician Phone** _____

Practice Specialty _____ **Physician Fax** _____

Genetic Counselor _____ **Counselor Phone** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply and describe)

☐ Axillary or inguinal freckling
☐ Café au lait macules (indicate number) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+
☐ Dermal fibromas
☐ Learning disabilities
☐ Lisch nodules (iris hamartomas)
☐ Malignant peripheral nerve sheath tumor (MPNST)
☐ Optic glioma (age at diagnosis:_____)
☐ Overgrowth (describe): _____
☐ Scoliosis
☐ Specific osseous lesions such as tibial pseudarthrosis or sphenoid dysplasia (describe): _____
☐ Vertebral dysplasia
☐ Other symptom(s): _____

Has the patient undergone previous germline DNA testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

_____

Does this patient have *NF1* genetic variant(s) previously identified in tumor/bone marrow? ☐ No ☐ Yes ☐ Unknown

If yes, attach results or describe: _____

Is there any relevant family history? ☐ No ☐ Yes; *NF1* ☐ Yes; Legius ☐ Yes; neither (*NF1* nor Legius) ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset: _____

_____

_____

Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Check the test you intend to order.

☐ **2007154 Neurofibromatosis, Type 1 (*NF1*) Sequencing and Deletion/Duplication:** Detects 84–93% of *NF1*.

☐ **2007159 Neurofibromatosis, Type 1 (*NF1*) Sequencing:** Detects 77–86% of *NF1*.

☐ **2001952 Neurofibromatosis Type 1 (*NF1*) Deletion/Duplication:** Detects 7% of *NF1*.

☐ **2008347 Legius Syndrome (*SPRED1*) Sequencing and Deletion/Duplication:** Sensitivity for Legius is unknown.

☐ **2002945 Legius Syndrome (*SPRED1*) Sequencing:** Sensitivity for Legius is unknown.

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

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

Master Label