ARUP LABORATORIES

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

PATIENT HISTORY FOR HEREDITARY RENAL CANCER 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 patient have CLINICAL FINDINGS? [ ] No [ ] Yes. If yes, fill out information below OR send a copy of a recent clinic note outlining patient's clinical findings and relevant testing results.

Patient's diagnosis: _____ [ ] Confirmed [ ] Suspected [ ] Unknown

Has the patient been diagnosed with cancer? [ ] No [ ] Yes, check all that apply and describe

[ ] Renal (age of onset _____, type _____, [ ] Bilateral/ [ ] Unilateral, [ ] Multifocal/ [ ] Monoclonal)
[ ] Breast (age____) [ ] Melanoma (age____) [ ] Pheochromocytoma (age____)
[ ] Colorectal (age____) [ ] Ovarian (age____) [ ] Thyroid (age____)
[ ] Endometrial (age____) [ ] Pancreatic (age____) [ ] Other:_____ (age___)
[ ] Gastric (age____) [ ] Paraganglioma (age____)

Additional clinical findings? [ ] No [ ] Yes. If yes, please check all that apply and describe:
[ ] Cutaneous: _____
[ ] Gastrointestinal: _____
[ ] Musculoskeletal/Neurological: _____
[ ] Other: _____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? [ ] No [ ] Yes [ ] Unknown

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

Is there any relevant FAMILY HISTORY? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the relative's relationship to the patient, symptoms/clinical diagnosis and age of onset.
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
Attach a copy of the relative's DNA laboratory result. REQUIRED for familial mutation testing.

Circle the test you intend to order.

Recommended first tier testing for hereditary renal cancer syndromes
2010214 Renal Hereditary Cancer Panel, Sequencing and Deletion/Duplication, 15 Genes
Targeted testing for a known mutation (laboratory report from family member REQUIRED)
2001961 Familial Mutation, Targeted Sequencing: Targeted testing for a known familial sequence mutation.

Analysis of specific genes included in this panel may be offered individually at ARUP. For test availability and further information, please see www.aruplab.com/genetics.

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

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