

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform Multiple Endocrine Neoplasia 2, *RET* Gene testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR MULTIPLE ENDOCRINE NEOPLASIA 2, *RET* GENE 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)

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Does the patient have a diagnosis of MEN2? Confirmed Suspected Unknown

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

- Medullary thyroid carcinoma (MTC) (Bilateral/ Unilateral, Monoclonal/ Multifocal, Age of onset: _____)
- Pheochromocytoma (Bilateral Unilateral, Age of onset: _____)
- Hyperparathyroidism (Age of onset: _____)
- Parathyroid hyperplasia (Age of onset: _____)
- Parathyroid adenoma (Age of onset: _____)
- Skeletal abnormalities (describe: _____)
- Eye abnormalities (describe: _____)
- Neuromas (describe: _____)
- Hirschsprung disease
- Other _____

Laboratory Findings

- | | | | |
|---------------------|-----------------------------------|---------------------------------|----------------------------------|
| Calcitonin | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Calcium | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Parathyroid Hormone | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Catecholamines | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |

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

Does the patient have a **FAMILY HISTORY** of MEN2 or related findings? No Yes Unknown
 If yes, specify the **RELATIONSHIP** of the affected family member(s) to the patient and detail the symptoms/age of onset in each.

Please attach a copy of the relative's *RET* laboratory result (REQUIRED for familial mutation testing)

Circle the MULTIPLE ENDOCRINE NEOPLASIA 2 (*RET*) test you intend to order.

0051390 Multiple Endocrine Neoplasia Type 2 (MEN2), *RET* Gene Mutations by Sequencing

Sequencing of *RET* exons 10, 11, 13-16 with 95%, 88%, and 98% clinical sensitivity for MEN2A, Familial Medullary Thyroid Carcinoma, and MEN2B respectively. Order for individuals with MTC and/or other findings suggestive of MEN2.

2001961 Familial Mutation, Targeted Sequencing - Tests for a *RET* sequence change previously identified in a family member; copy of relative's lab result is REQUIRED.

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

Master Label