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 MULTIPLE ENDOCRINE NEOPLASIA TYPE 2 (*RET*) GENE TESTING

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 a diagnosis of *MEN2*? ☐ Confirmed ☐ Suspected ☐ Unknown

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

☐ Medullary thyroid carcinoma (MTC) (age of onset: _____) ☐ Bilateral/☐ Unilateral ☐ Monoclonal/☐ Multifocal
☐ Pheochromocytoma ..... (age of onset: _____) ☐ Bilateral/☐ Unilateral
☐ 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 symptom(s): _____

Laboratory Findings

☐ Calcitonin..... ☐ Abnormal ☐ Normal ☐ Unknown
☐ Calcium..... ☐ Abnormal ☐ Normal ☐ Unknown
☐ Parathyroid hormone... ☐ Abnormal ☐ Normal ☐ Unknown
☐ Catecholamines..... ☐ Abnormal ☐ Normal ☐ Unknown

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

Has the patient undergone previous DNA testing? ☐ No ☐ Yes ☐ Unknown
If yes, describe the genes, 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. 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.

☐ **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; a copy of relative's lab result is REQUIRED.

Master Label

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