ARUP LABORATORIES

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

PATIENT HISTORY FOR PEUTZ-JEGHERS SYNDROME 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 of Peutz-Jeghers Syndrome? [ ] No [ ] Yes

Does the patient have POLYPS? [ ] **Yes** [ ] **No** [ ] **Never Scoped** [ ] **Unknown**
If yes, number of polyps: _____
Location(s): [ ] Colorectal [ ] Small Bowel [ ] Gastric
Polyp Histopathology: [ ] adenomatous [ ] hamartomatous [ ] Unknown [ ] NA

Does the patient have HYPERPIGMENTED MACULES? [ ] **Yes** [ ] **No** [ ] **Unknown**
If yes, indicate which locations [ ] Around mouth [ ] Around Eyes [ ] Around nostrils [ ] Perianally
[ ] Buccal mucosa [ ] Fingers [ ] Other location_____

Has the patient been diagnosed with cancer? [ ] No [ ] Yes **If yes, check all that apply:**
[ ] Colorectal (age_____) [ ] Gastric (age_____) [ ] Small intestine (age_____) [ ] Pancreatic (age_____)
[ ] Breast (age_____) [ ] Ovarian (age_____) [ ] Other _____ (age_____)

Has the patient undergone previous DNA testing for Peutz-Jeghers syndrome? [ ] No [ ] Yes
If yes, please describe test(s) and results_____

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

Does the patient have a FAMILY HISTORY of Peutz-Jeghers syndrome? [ ] No [ ] Yes [ ] Unknown
If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms in each.
_____

Please attach PEDIGREE if possible.

Circle the Peutz-Jeghers test you intend to order – If questions, call ARUP Genetic Counselors at (800) 242-2787 x2946 or x3439.

2008398 Peutz-Jeghers Syndrome (*STK11*) Sequencing and Deletion/Duplication; clinical sensitivity is 99% in individuals with a family history of PJ and 91% in individuals without a family history of PJS.

2008394 Peutz-Jeghers Syndrome (*STK11*) Sequencing; clinical sensitivity is 55% in individuals with a family history of PJS and 70% in individuals without a family history of PJS.

2008377 Peutz-Jeghers Syndrome (*STK11*) Deletion/Duplication; clinical sensitivity is 45% in individuals with a family history of PJS and 21% in individuals without a family history of PJS. **Also order for familial *STK11* large deletion or duplication testing.**

2001961 Familial Mutation, Targeted Sequencing;. Tests for an *STK11* sequence change identified in a family member. A copy of relative's DNA laboratory result is REQUIRED for familial mutation testing.

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

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