ARUP LABORATORIES

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

PATIENT HISTORY FOR HEREDITARY BREAST AND OVARIAN CANCER (HBOC) 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_____

Has the patient been diagnosed with cancer? [ ] No [ ] Yes If yes, check all that apply:

[ ] Breast; (age _____); [ ] bilateral [ ] unilateral
[ ] Ovarian; (age _____); [ ] bilateral [ ] unilateral
[ ] Endometrial (age_____)
[ ] Fallopian (age_____)
[ ] Pancreatic (age_____)
[ ] Prostate (age_____)
[ ] ER-/PR-/HER2- ("triple negative") pathology
[ ] Colon (age _____)
[ ] Gastric (age _____)
[ ] Kidney (age_____)
[ ] Brain (age_____)
[ ] Thyroid (age_____)
[ ] Other _____ (age_____)

Has the patient undergone previous germline DNA testing for BRCA1/BRCA2 or other cancer syndrome? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results_____

Does the patient have a FAMILY HISTORY of breast, ovarian, or related cancers? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify each relative's relationship to the patient, symptoms and age at diagnosis.
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results and attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing):_____
For assistance with test selection when a relative has been tested previously, please contact an ARUP Genetic Counselor at (800) 242-2787 ext. 2141.

Does this patient have genetic variant(s) previously identified in tumor/bone marrow? [ ] No [ ] Yes [ ] Unknown
If yes, please attach result or describe _____

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

Circle the HBOC test you intend to order:

Recommended testing for HBOC <u>when a relative HAS NOT been tested previously</u>:	
2012026	**Breast and Ovarian Hereditary Cancer Panel, Sequencing and Deletion/Duplication, 20 Genes;** clinical sensitivity is estimated at 20 -60% in individuals with HBOC syndrome.
2011949	**Breast and Ovarian Hereditary Cancer (*BRCA1* and *BRCA2*) Sequencing and Deletion/Duplication**; clinical sensitivity is ~90% for *BRCA1/2*.
2011954	**Breast and Ovarian Hereditary Cancer (*BRCA1* and *BRCA2*) Sequencing;** clinical sensitivity is ~80% for *BRCA1/2*.
Recommended testing <u>when a relative HAS been tested previously (laboratory report from family member REQUIRED)</u>	
2001961	**Familial Mutation, Targeted Sequencing**- targeted testing for a known familial sequence variant
2011915	**Breast and Ovarian Hereditary Cancer (*BRCA1* and *BRCA2*) Deletion/Duplication;** clinical sensitivity is ~10% for *BRCA1/2*. Only order if there is a known familial *BRCA1* or *BRCA2* large deletion/duplication.

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

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