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 HEREDITARY BREAST AND OVARIAN CANCER (HBOC) 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: _____

Has the patient been diagnosed with cancer? ☐ No ☐ Yes (check all that apply)

☐ Brain (age: _____)
☐ Breast (age: _____)
☐ bilateral ☐ unilateral
☐ ER-/PR-/HER2- "triple negative" pathology
☐ Colon (age: _____)
☐ Endometrial (age: _____)
☐ Fallopian (age: _____)
☐ Gastric (age: _____)
☐ Kidney (age: _____)
☐ Ovarian (age: _____)
☐ bilateral ☐ unilateral
☐ Pancreatic (age: _____)
☐ Prostate (age: _____)
☐ Skin (melanoma) (age: _____)
☐ Skin (non-melanoma) (age: _____)
☐ Thyroid (age: _____)
☐ Other: _____ (age: _____)

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

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

Has the patient undergone previous germline DNA testing for *BRCA1/BRCA2* or other cancer syndrome? ☐ No ☐ Yes ☐ Unknown
If yes, describe the test(s) and result(s): _____

Is there any relevant family history of breast, ovarian, or related cancers? ☐ No ☐ Yes ☐ Unknown
If yes, attach a pedigree or specify each affected relative's relationship to the patient. List their symptoms and age at diagnosis:

_____

_____

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). For assistance with test selection when a relative has been tested previously, please contact an ARUP Genetic Counselor at (800)242-2787, ext. 2141

Check the test you intend to order:

Recommended first tier testing for HBOC syndromes

☐ **2012026 Hereditary Breast and Ovarian Cancer Panel, Sequencing and Deletion/Duplication**: clinical sensitivity is at least 20–60% in individuals with HBOC.
☐ **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*.

Targeted testing for known mutation

☐ **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.
☐ **2001961 Familial Mutation, Targeted Sequencing:** tests for a mutation previously identified in a family member; a copy of the relative's lab result is REQUIRED.

Master Label

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