ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, Utah 84108-1221
phone: (801) 583-2787 | toll free: (800) 242-2787
fax: (801) 584-5249 | www.aruplab.com

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 CANCER PANEL

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 a tumor or cancer? ☐ No ☐ Yes (Check all that apply and indicate age of diagnosis.)

☐ Adrenal (age _____) ☐ Nonmedullary thyroid (age _____)
☐ Brain (type/age _____) ☐ Ovarian (age _____)
☐ Breast (age _____) ☐ Pancreatic (age _____)
☐ Colorectal (age _____) ☐ Parathyroid (age _____)
☐ Endometrial (age _____) ☐ Pheochromocytoma (age _____)
☐ Gastric (age _____) ☐ Pituitary (age _____)
☐ Leukemia (age _____) ☐ Prostate (age _____)
☐ Medullary thyroid (age _____) ☐ Renal (age _____)
☐ Melanoma (age _____) ☐ Other: _____

Has the patient undergone previous DNA testing for this condition? ☐ No ☐ Yes ☐ Unknown
If yes, describe the genes, method, and results: _____

Is there any relevant family history of cancers or tumors? ☐ 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). 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 hereditary cancer syndromes
(Specific genes in these panels may be available individually. See www.aruplab.com/genetics)

☐ **2012032 Hereditary Cancer Panel, Sequencing and Deletion/Duplication**

☐ **2013449 Hereditary Gastrointestinal Cancer Panel, Sequencing and Deletion/Duplication**

☐ **2012026 Hereditary Breast and Ovarian Cancer Panel, Sequencing and Deletion/Duplication**

☐ **2010214 Hereditary Renal Cancer Panel, Sequencing and Deletion/Duplication**

Targeted testing for known mutation

☐ **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