ARUP LABORATORIES

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

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

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD)

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have a clinical diagnosis of ADPKD? ☐ No ☐ Confirmed ☐ Suspected ☐ Unknown

Is this patient being evaluated as a potential living related kidney donor? ☐ No ☐ Yes ☐ Unknown

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

☐ Abdominal wall hernia
☐ Aortic dissection/dilatation
☐ End stage renal disease (ESRD) (age of onset: _____)
☐ Enlarged kidneys
☐ Hypertension
☐ Intracranial aneurysms
☐ Mitral valve prolapse
☐ Renal cysts (total number: _____) ☐ bilateral ☐ unilateral
☐ Renal insufficiency
☐ Other symptom(s): _____

Has the patient had renal imaging studies? ☐ No ☐ Yes ☐ Unknown
If yes, describe imaging results: ☐ Normal ☐ Abnormal: _____ ☐ Uncertain: _____

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.

Recommended first tier testing for ADPKD:

☐ **2012250 Polycystic Kidney Disease, Autosomal Dominant (*PKD1* and *PKD2*) Sequencing and Deletion/Duplication:**
Clinical sensitivity 90% for ADPKD.

☐ **2012255 Polycystic Kidney Disease, Autosomal Dominant (*PKD1* and *PKD2*) Sequencing:**
Clinical sensitivity 87% for ADPKD.

Targeted testing for known mutation (a copy of the laboratory report from a family member is REQUIRED):

☐ **2001961 Familial Mutation, Targeted Sequencing:**
Tests for sequence variant(s) previously identified in a family member; copy of relative's lab result is REQUIRED.

☐ **3003144 Deletion/Duplication Analysis by MLPA:**
Tests for large deletion/duplication previously identified in a family member, a copy of a relative's lab report is REQUIRED.

Master Label

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