ARUP LABORATORIES

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

PATIENT HISTORY FOR AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD) 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 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 of ADPKD? [ ] No [ ] Yes; please check all that apply

[ ] Renal cysts:
[ ] bilateral [ ] unilateral;
total #_____
[ ] Enlarged kidneys

[ ] Renal insufficiency
[ ] End stage renal disease (ESRD)
Age of onset: _____
[ ] Hypertension

[ ] Aortic dissection/dilatation
[ ] Abdominal wall hernia
[ ] Mitral valve prolapse
[ ] Intracranial aneurysms
[ ] Other_____

Has the patient had renal imaging studies? [ ] No [ ] Yes [ ] Unknown
Imaging Results: [ ] Normal [ ] Abnormal _____ [ ] Uncertain _____

Does the patient have a FAMILY HISTORY of ADPKD? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family members to the patient and detail the symptoms/age of onset in each symptomatic relative:
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, please attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing)

Has the patient undergone previous DNA testing for PKD? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results: _____

Circle the test you intend to order

Recommended first tier testing for Autosomal Dominant Polycystic Kidney Disease:	
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.
2012246	**Polycystic Kidney Disease, Autosomal Dominant (*PKD1* and *PKD2*) Deletion/Duplication**: Clinical sensitivity 3% for ADPKD. Tests for large deletions/duplications when *PKD1* and *PKD2* sequencing was negative.
Targeted testing for known mutation (laboratory report from family member REQUIRED)	
2012246	**Polycystic Kidney Disease, Autosomal Dominant (*PKD1* and *PKD2*) Deletion/Duplication**: Tests for a large deletion/duplication previously identified in a family member.
2001961	**Familial Mutation, Targeted Sequencing**: Targeted testing for a known familial sequence mutation.

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

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