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 AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD)

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: _____

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):

☐ **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:** Tests for a mutation previously identified in a family member; copy of relative's lab result is REQUIRED.

Master Label

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