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 GASTROINTESTINAL (GI) CANCER 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: _____

Clinical Diagnosis: ☐ Confirmed ☐ Suspected ☐ Unknown

Does the patient have polyps? ☐ No ☐ Yes ☐ Never Scoped or Unknown

If yes, number of polyps: _____ Location of Polyps: ☐ Colorectal ☐ Small Bowel ☐ Gastric

Polyp histopathology: ☐ Adenomatous ☐ Hamartomatous ☐ Unknown ☐ Other: _____

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

☐ Breast	(age:_____)	☐ Ovarian	(age:_____)	☐ Paraganglioma	(age:_____)
☐ Colon	(age:_____)	☐ Pancreatic	(age:_____)	☐ Renal	(age:_____)
☐ Endometrial	(age:_____)	☐ Pheochomocytoma	(age:_____)	☐ Rectal	(age:_____)
☐ Gastric	(age:_____)			☐ Thyroid	(age:_____)

☐ Other: _____ (age:_____)

Does the patient have additional clinical findings (i.e. cutaneous, GI, musculoskeletal/neurological, or vascular)? ☐ No ☐ Yes

If yes, describe: _____

Has the patient undergone previous tumor IHC or MSI testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the results: _____

Has the patient undergone previous DNA testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the genes, methodology, and results: _____

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

Is there any relevant family history of gastrointestinal cancers? ☐ 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 gastrointestinal cancer syndromes

☐ **2013449 Hereditary Gastrointestinal Cancer Panel, Sequencing and Deletion/Duplication**
Specific genes in this panel may be available individually.
See www.aruplab.com/genetics.

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.

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

Master Label