

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

PATIENT HISTORY FOR PANCREATITIS 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)

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Does the patient have SYMPTOMS? No Yes (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Oily stools | <input type="checkbox"/> Malabsorption/Weight loss |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea and Vomiting | <input type="checkbox"/> Elevated Amylase and Lipase |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ | |

PATIENT'S DIAGNOSIS

- | | | |
|---|---|--|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Chronic Pancreatitis | <input type="checkbox"/> Hereditary Pancreatitis |
| <input type="checkbox"/> Acute Pancreatitis | <input type="checkbox"/> Recurrent Pancreatitis | <input type="checkbox"/> Other _____ |

PATIENT RISK FACTORS FOR PANCREATITIS? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> None (idiopathic) | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Infection _____ |
| <input type="checkbox"/> Heavy alcohol use | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Medication _____ |
| <input type="checkbox"/> Hypercalcemia | <input type="checkbox"/> Abdominal Trauma | <input type="checkbox"/> Autoimmune _____ |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Other _____ | |

Does the patient have a FAMILY HISTORY of Pancreatitis Cystic Fibrosis Neither Unknown

If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family members(s) to the patient and detail the symptoms/age of onset in each symptomatic relative. _____

Has DNA testing been performed for these family member(s)? Yes No Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for Pancreatitis Cystic Fibrosis Neither Unknown

If yes, please describe test(s) and results _____

Circle the Pancreatitis test you intend to order.

2010876 Pancreatitis Panel (CFTR, CTRC, PRSS1 and SPINK1) Sequencing - Clinical sensitivity for idiopathic pancreatitis of ~50% and hereditary pancreatitis of 80%.

2010703 Pancreatitis (CTRC) Sequencing- Clinical sensitivity for idiopathic pancreatitis of ~4%.

2002016 Pancreatitis (PRSS1) Sequencing - Clinical sensitivity for hereditary pancreatitis of 80% and 10% for idiopathic pancreatitis.

2002012 Pancreatitis (SPINK1) Sequencing - Clinical sensitivity for idiopathic pancreatitis of 15%.

2001961 Known Familial Mutation Sequencing: Tests for specific mutation(s) identified in a family member. A copy of the relative's DNA lab result is REQUIRED for this test.

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

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