ARUP LABORATORIES

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

PATIENT HISTORY FOR *PTEN* HAMARTOMA TUMOR SYNDROME (PHTS) 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_____

Patient's clinical diagnosis

[ ] Cowden Syndrome [ ] Bannayan-Riley-Ruvalcaba Syndrome [ ] Proteus Syndrome
[ ] Proteus-Like Syndrome [ ] Mental retardation/autism [ ] Other _____

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

[ ] Breast cancer (age: _____)
[ ] Follicular thyroid cancer (age: _____)
[ ] Papillary thyroid cancer (age: _____)
[ ] Endometrial cancer (age: _____)
[ ] Lhermitte-Duclos disease (cerebellar tumor)
[ ] Macrocephaly
[ ] Mental retardation/ developmental delay
[ ] Trichilemmomas
[ ] Keratoses (location: _____)
[ ] Papillomatous papules
[ ] Pigmented macules of glans penis
[ ] Tissue overgrowth
[ ] Nevi ([ ] connective tissue, [ ] epidermal)
[ ] Lipomas
[ ] GI hamartoma (location: _____, number_____)
[ ] Skeletal abnormalities (describe: _____)
[ ] Vascular malformation (describe: _____)
[ ] Other _____

Does the patient have a FAMILY HISTORY of any of the above symptoms? [ ] No [ ] Yes [ ] 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 copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for *PTEN*? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results_____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? [ ] No [ ] Yes [ ] Unknown

Circle the *PTEN* test you intend to order.

2002470 *PTEN*–Related Disorders, Sequencing and Deletion/Duplication - Sequencing and deletion/duplication analysis of *PTEN* coding regions and intron/exon boundaries with a clinical sensitivity of 85% for Cowden, 65% for Bannayan-Riley-Ruvalcaba and 20% for Proteus syndrome.

2002722 *PTEN*-Related Disorders (PTEN) Sequencing

2001961 Familial Mutation, Targeted Sequencing - Tests for a *PTEN* sequence change identified in a family member. A copy of relative's DNA laboratory result is REQUIRED.

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

Master Label