

**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)

- |   |   |  |                                      |
|---|---|--|--------------------------------------|
| <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 _____ |

**Patient's clinical diagnosis**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cowden Syndrome       | <input type="checkbox"/> Bannayan-Riley-Ruvalcaba Syndrome | <input type="checkbox"/> Proteus Syndrome |
| <input type="checkbox"/> Proteus-Like Syndrome | <input type="checkbox"/> Mental retardation/autism         | <input type="checkbox"/> Other _____      |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Breast cancer (age: _____)                   | <input type="checkbox"/> Trichilemmomas                              |
| <input type="checkbox"/> Follicular thyroid cancer (age: _____)       | <input type="checkbox"/> Keratoses (location: _____)                 |
| <input type="checkbox"/> Papillary thyroid cancer (age: _____)        | <input type="checkbox"/> Papillomatous papules                       |
| <input type="checkbox"/> Endometrial cancer (age: _____)              | <input type="checkbox"/> Pigmented macules of glans penis            |
| <input type="checkbox"/> Lhermitte-Duclos disease (cerebellar tumor)  | <input type="checkbox"/> Tissue overgrowth                           |
| <input type="checkbox"/> Macrocephaly                                 | <input type="checkbox"/> Nevi ([ ] connective tissue, [ ] epidermal) |
| <input type="checkbox"/> Mental retardation/ developmental delay      | <input type="checkbox"/> Lipomas                                     |
| <input type="checkbox"/> GI hamartoma (location: _____, number _____) |  |
| <input type="checkbox"/> Skeletal abnormalities (describe: _____)     |  |
| <input type="checkbox"/> Vascular malformation (describe: _____)      |  |
| <input type="checkbox"/> 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 member(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**

**2002726 *PTEN*-Related Disorders (*PTEN*) Deletion/Duplication**

**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