

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

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

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