

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform von Hippel-Lindau Syndrome/congenital polycythemia testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR VON HIPPEL-LINDAU SYNDROME/CONGENITAL POLYCYTHEMIA (VHL) 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 _____

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

- Retinal hemangioblastoma Cerebellar hemangioblastoma Spinal hemangioblastoma
 Clear cell renal carcinoma Pheochromocytoma Endolymphatic sac tumor
 Other _____

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

- Headache Plethora Thrombotic/vascular event (describe _____)
 Other _____

LABORATORY FINDINGS suggestive of polycythemia? No Yes, describe below

Hematocrit _____% Erythropoietin _____ U/mL
Hemoglobin concentration _____ g/dL Red blood cells _____ x10⁶/μL

Other _____

Has the patient undergone previous DNA testing for VHL? 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

Does the patient have a FAMILY HISTORY of VHL Polycythemia Neither 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).

Circle the VHL test you intend to order.

2002965 Von Hippel-Lindau (VHL) Sequencing and Deletion/Duplication

Sequencing and deletion/duplication analysis of the *VHL* gene with a clinical sensitivity of 99% for VHL syndrome. Please do not order for congenital polycythemia as large deletions/duplications have not been reported as causative.

2002970 Von Hippel-Lindau (VHL) Sequencing

Sequencing of *VHL* coding regions and intron/exon boundaries with a clinical sensitivity of 72% for VHL syndrome and ~20% for congenital polycythemia.

2002988 Von Hippel-Lindau (VHL) Deletion/Duplication

Deletion/duplication analysis of *VHL*; clinical sensitivity is 28% for VHL syndrome. Please do not order for congenital polycythemia as large deletions/duplications have not been reported as causative.

2001961 Familial Mutation, Targeted Sequencing

Targeted sequencing of specific *VHL* gene mutations requires submission of the affected family member's report.

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

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