ARUP LABORATORIES

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 _____ $x10^{-6}/\mu L$
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 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).

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.

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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