ARUP LABORATORIES

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

PATIENT HISTORY FOR FAMILIAL ADENOMATOUS POLYPOSIS 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? [ ] Yes [ ] No [ ] Unknown If yes, what is the patient's clinical diagnosis?
[ ] FAP [ ] Attenuated FAP [ ] MUTYH-associated polyposis (MAP)
[ ] Turcot Syndrome [ ] Gardner Syndrome [ ] Other _____

Does the patient have polyps? [ ] **Yes** [ ] **No** [ ] **Never Scoped** [ ] **Unknown**
If yes, number of polyps: [ ] <10 [ ] 10-49 [ ] 50-99 [ ] 100-500 [ ] >500
Location(s):[ ] Colon [ ] Gastric [ ] Duodenal

Has histopathology confirmed that the polyps are adenomatous? [ ] No [ ] Yes [ ] Unknown [ ] NA

Has the patient been diagnosed with cancer? [ ] No [ ] Yes **If yes, check all that apply:**
[ ] Colon (age_____) [ ] Gastric (age_____) [ ] Hepatoblastoma (age_____) [ ] Medulloblastoma (age_____)
[ ] Rectal (age_____) [ ] Thyroid (age_____) [ ] Other _____ (age_____)

Other clinical manifestations?
[ ] CHRPE [ ] Desmoid tumors [ ] Epidermoid cysts [ ] Osteomas

Has the patient undergone previous DNA testing for FAP/Polyposis? [ ] No [ ] Yes
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 FAP/Polyposis? [ ] No [ ] Yes [ ] Unknown
If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic/affected relative._____
_____

Please attach a copy of the PEDIGREE and a relative's DNA laboratory result.

Circle the test you intend to order.

2004915 Familial Adenomatous Polyposis Panel: ***APC*** **Sequencing and Deletion/Duplication, (*MUTYH)* 2 Mutations**

2004863 Familial Adenomatous Polyposis (*APC)* Sequencing: Clinical sensitivity is ~90% for FAP.

2004920 Familial Adenomatous Polyposis (*APC)* Deletion/Duplication: Clinical sensitivity ~8-12% for FAP. **Also order for familial *APC* large deletion or duplication testing.**

2006307 *MYH*-Associated Polyposis (*MUTYH*) 2 Mutations with Reflex to Sequencing: Detects 98% of MAP.

2006191 *MYH*-Associated Polyposis (*MUTYH*) Sequencing: Full sequencing of the *MUTYH* gene. Detects 98% of MAP.

2004911 *MUTYH*-Associated Polyposis (*MUTYH*) 2 Mutations

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

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

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