

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform Multiple Endocrine Neoplasia Type 1 (MEN1), Gene testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR MULTIPLE ENDOCRINE NEOPLASIA TYPE 1 (MEN1) GENE 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 _____ |

Does the patient have a diagnosis of MEN1? Confirmed Suspected Unknown

Does the patient have SYMPTOMS? No Yes, check all that apply

Endocrine tumor

- Parathyroid
- Pituitary
- Gastro-entero-pancreatic (GEP):
 - Gastrinoma
 - Insulinoma
 - Glucagonoma
 - VIPoma
- Other: _____

Non-endocrine tumor

- Facial angiofibroma
- Collagenoma
- Lipoma
- Ependymoma
- Leiomyoma
- Meningioma
- Other: _____

Laboratory findings

- | | | |
|--------------|-----------------------------------|---------------------------------|
| Parathyroid: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Calcium: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Prolactin: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Gastrin: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Cortisol: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Insulin: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Proinsulin | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| C-peptide | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Other: | _____ | |

Does the patient have a FAMILY HISTORY of MEN1 or related findings? No Yes 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)? No Yes Unknown

If yes, attach copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing? No Yes Unknown

If yes, please describe the gene/disorder, methodology, and results _____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? No Yes Unknown

Circle the test you intend to order.

2005360 Multiple Endocrine Neoplasia Type 1 (MEN1), Sequencing and Deletion/Duplication; Sequence analysis and MLPA of *MEN1* coding regions; clinical sensitivity approaches 94%.

2005359 Multiple Endocrine Neoplasia Type 1 (MEN1), Sequencing; Sequence analysis of *MEN1* coding regions; clinical sensitivity approaches 90%.

2001961 Familial Mutation, Targeted Sequencing; Tests for a *MEN1* sequence change identified in a family member; copy of relative's lab result is REQUIRED.

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

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