ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

TUBEROUS SCLEROSIS COMPLEX PANEL PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have a diagnosis of Tuberous Sclerosis Complex (TSC)? ☐ Confirmed ☐ Suspected ☐ Unknown

Does the patient have clinical symptoms? ..... ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Skin
- ☐ Hypomelanotic macules .(#_____)
- ☐ Confetti skin lesions
- ☐ Facial angiofibromas .....(#_____)
- ☐ Shagreen patch
- ☐ Ungula fibromas .....(#_____)

☐ Central Nervous System
- ☐ Subependymal nodules
- ☐ Cortical dysplasias
- ☐ Subependymal giant cell astrocytoma
- ☐ Seizures

- ☐ Cognitive impairment (specify:_____)
- ☐ Renal angiomyolipoma
- ☐ Renal cysts .....(#_____)
- ☐ Cardiac rhabdomyoma
- ☐ Pulmonary lymphangioleiomyomatosis (LAM)
- ☐ Retinal hamartomas
- ☐ Retinal achromic patches

☐ Other symptom(s): _____

Does the patient have a FAMILY HISTORY of TSC or individuals with findings of TSC? ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a PEDIGREE or specify the relatives' RELATIONSHIP to the patient. List their symptoms and age of onset:

Has DNA testing been performed for these family member(s)? ..... ☐ No ☐ Yes ☐ Unknown

Has the patient undergone previous DNA testing for TSC? ..... ☐ No ☐ Yes ☐ Unknown

If yes, please describe test(s) and results: _____

Master Label

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