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.

NEUROFIBROMATOSIS TYPE 1 (NF1) AND LEGIUS SYNDROME 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 symptoms? ..... ☐ No ☐ Yes (check all that apply and describe)

☐ Axillary or inguinal freckling

☐ Café au lait macules (indicate number)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

☐ Dermal fibromas

☐ Learning disabilities

☐ Lisch nodules (iris hamartomas)

☐ Malignant peripheral nerve sheath tumor (MPNST)

☐ Optic glioma (age at dx): _____

☐ Osseous lesion (describe): _____

☐ Overgrowth (describe): _____

☐ Scoliosis

☐ Other symptoms: _____

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

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

Does this patient have *NF1* or *SPRED1* genetic variant(s) previously identified in tumor/bone marrow?

..... ☐ No ☐ Yes ☐ Unknown

If yes, attach results and describe: _____

Is there any relevant family history? ..... ☐ No ☐ Yes; NF1 ☐ Yes; Legius ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

_____

_____

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

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

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

Master Label