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.

PATIENT HISTORY FOR HEREDITARY PARAGANGLIOMA-PHEOCHROMOCYTOMA TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

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

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

Genetic Counselor: _____ **Counselor 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) ☐ Unknown

☐ Pheochromocytoma ..... (age at diagnosis:_____)
☐ Bilateral ☐ Unilateral

☐ Paraganglioma ..... (age at diagnosis_____)
☐ Parasympathetic (generally nonsecretory)
☐ Sympathetic (generally secretory)
Location(s):_____

☐ Malignant paraganglioma/pheochromocytoma
(age at diagnosis_____)
Location(s):_____

☐ Renal cell carcinoma ..... (age at diagnosis:_____)

☐ Breast cancer..... (age at diagnosis:_____)

☐ Papillary thyroid cancer..... (age at diagnosis:_____)

☐ Gastrointestinal stromal tumors (GISTs)
(age at diagnosis: _____)

☐ Erythrocytosis/polycythemia
(age at diagnosis:_____)

☐ Other symptom(s): _____

Laboratory Findings

Epinephrine (adrenaline).....	☐ Abnormal	☐ Normal	☐ Unknown	☐ Not Performed
Norepinephrine (noradrenaline).....	☐ Abnormal	☐ Normal	☐ Unknown	☐ Not Performed
Dopamine.....	☐ Abnormal	☐ Normal	☐ Unknown	☐ Not Performed

Result by Immunohistochemistry (IHC)

☐ Absent *TEI C* ☐ Normal *TEI C* staining ☐ Indeterminate ☐ Unknown ☐ Not performed

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

If yes, describe the genes, disorder, methodology, and results: _____

Is there any relevant family history?..... ☐ No ☐ Yes ☐ 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 mutation testing).

Check the test you intend to order.

☐ **2007167 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*, *SDHC*, and *SDHD*) Sequencing and Deletion/Duplication**

☐ **2007108 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*) Sequencing and Deletion/Duplication**

☐ **2011461 Hereditary Paraganglioma-Pheochromocytoma (*SDHA*) Sequencing**

☐ **2007117 Hereditary Paraganglioma-Pheochromocytoma (*SDHC*) Sequencing and Deletion/Duplication**

☐ **2007122 Hereditary Paraganglioma-Pheochromocytoma (*SDHD*) Sequencing and Deletion/Duplication**

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; copy of relative's lab result is REQUIRED

Master Label

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