ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HEREDITARY PARAGANGLIOMA-PHEOCHROMOCYTOMA TESTING

Patient Name _____ **Date of Birth** _____ **Sex** ☐ F ☐ M

Physician _____ **Physician Phone** _____

Practice Specialty _____ **Physician Fax** _____

Genetic Counselor _____ **Counselor Phone** _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply and describe)

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

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

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

☐ 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 *SDHB* ☐ Normal *SDHB* 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**
☐ **2011461 Hereditary Paraganglioma-Pheochromocytoma (*SDHA*) Sequencing**
☐ **2007108 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*) Sequencing and Deletion/Duplication**
☐ **2007117 Hereditary Paraganglioma-Pheochromocytoma (*SDHC*) Sequencing and Deletion/Duplication**
☐ **2007122 Hereditary Paraganglioma-Pheochromocytoma (*SDHD*) Sequencing and Deletion/Duplication**
☐ **2007113 Hereditary Paraganglioma-Pheochromocytoma (*SDHB*, *SDHC*, *SDHD*)**
Deletion/Duplication: For patients who have had negative sequencing for one or more of the genes or if a deletion in one of these genes was previously identified in a family member; a copy of a relative's DNA laboratory result is REQUIRED.
☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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