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 NEUROFIBROMATOSIS TYPE 1/LEGUIS SYNDROME

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 and describe)

☐ Axillary or inguinal freckling

☐ Cafè 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 diagnosis:_____)

☐ Overgrowth (describe): _____

☐ Scoliosis

☐ Specific osseous lesions such as tibial pseudarthrosis or sphenoid dysplasia (describe): _____

☐ Vertebral dysplasia

☐ Other symptom(s): _____

Has the patient undergone previous germline or tumor DNA testing of *NF1* or *SPRED1* genes? ☐ No ☐ Yes ☐ Unknown

If yes, was testing of patient's germline or tumor? _____

Describe test result and include copy of lab report: _____

Is there any relevant family history? ☐ No ☐ Yes; *NF1* ☐ Yes; Legius ☐ Yes; neither (*NF1* nor 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, describe test result and include copy of lab report: _____

Check the test you intend to order.

☐ **2007154 Neurofibromatosis, Type 1 (*NF1*) Sequencing and Deletion/Duplication:** Detects 84-93% of *NF1*.

☐ **2008347 Legius Syndrome (*SPRED1)* Sequencing and Deletion/Duplication**

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

☐ **3003144 Deletion/Duplication Analysis by MLPA:** Tests large deletion/duplication previously identified in a family member; copy of relative's lab report is REQUIRED.

Master Label

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