

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

BIRT-HOGG-DUBÉ SYNDROME (BHDS) 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 clinical findings of BHDS?..... No Yes (check all that apply) Unknown

- | | | |
|---|---|---|
| <input type="checkbox"/> Acrochordons/skin tags | <input type="checkbox"/> Fibrofolliculomas (#: _____) | <input type="checkbox"/> Pulmonary cysts |
| <input type="checkbox"/> Cutaneous collagenomas | <input type="checkbox"/> Oral papules | <input type="checkbox"/> Trichodiscomas |
| <input type="checkbox"/> Epidermal cysts | <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Thyroid nodules/cancer |

Renal tumor/cancer; age of onset, histological type(s) and laterality: _____

Other cancer(s)/symptom(s): _____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant? No Yes Unknown

Has the patient undergone previous DNA testing for BHDS or other syndrome? No Yes Unknown

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

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

..... No Yes Unknown

If yes, attach result or describe: _____

Is there any relevant family history of BHDS symptoms or another known syndrome?..... 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 variant testing).

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

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