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.

HEREDITARY ERYTHROCYTOSIS 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 of erythrocytosis or associated conditions?

☐ No ☐ Yes (check all that apply below); age of onset _____ ☐ Unknown

☐ Cerebrovascular event
☐ Dizziness
☐ Epistaxis
☐ Fatigue
☐ Headaches
☐ Hemorrhagic events; describe: _____
☐ Hypotension
☐ Myeloproliferative neoplasm; describe: _____
☐ Myocardial infarction
☐ Neuroendocrine tumor; describe: _____
☐ Pulmonary hypertension
☐ Thrombotic events; describe: _____
☐ Varicose veins

☐ Other symptom(s): _____

What is the patient's smoking history? ☐ Never smoker ☐ Former smoker ☐ Current smoker

Laboratory findings: Serum erythropoietin (EPO) value: _____ ☐ Normal ☐ Low ☐ High

Hemoglobin (Hb) value: _____ ☐ Normal ☐ Low ☐ High

Hematocrit (Hct) value: _____ ☐ Normal ☐ Low ☐ High

Red blood cell count (RBC) value: _____ ☐ Normal ☐ Low ☐ High

Hemoglobin HPLC/capillary electrophoresis result: _____

Oxygen pressure at 50% Hb saturation (P_{50}): ☐ Normal ☐ Low

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

Has the patient undergone previous germline DNA testing for hereditary erythrocytosis? ☐ No ☐ Yes ☐ Unknown

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

Does this patient have a *JAK2* mutation or other genetic variant(s) previously identified in blood/bone marrow/tumor? ☐ No ☐ Yes ☐ Unknown

If yes, attach result or describe: _____

Is there any relevant family history of erythrocytosis? ☐ 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.

Master Label