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 RENAL CANCER 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: _____

Patient's diagnosis: ☐ Confirmed ☐ Suspected ☐ Unknown

Has the patient been diagnosed with cancer? ☐ No ☐ Yes (check all that apply and describe)

☐ Renal (age of onset _____)
Type: _____
☐ Unilateral ☐ Monoclonal
☐ Bilateral ☐ Multifocal

☐ Breast (age _____)

☐ Colorectal (age _____)

☐ Endometrial (age _____)
☐ Gastric (age _____)
☐ Melanoma (age _____)
☐ Ovarian (age _____)
☐ Pancreatic (age _____)

☐ Paraganglioma (age _____)
☐ Pheochromocytoma (age _____)
☐ Thyroid (age _____)
☐ Other: _____ (age _____)

Additional clinical findings? ☐ No ☐ Yes (check all that apply and describe)

☐ Cutaneous: _____
☐ Gastrointestinal: _____
☐ Musculoskeletal/Neurological: _____
☐ Other: _____

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

Has the patient undergone previous DNA testing for this condition? ☐ No ☐ Yes ☐ Unknown
If yes, describe the gene(s), 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). For assistance with test selection when a relative has been tested previously, please contact an ARUP Genetic Counselor at (800)242-2787, ext. 2141

Check the test you intend to order:

Recommended first tier testing for hereditary renal cancer syndromes

☐ **2010214 Hereditary Renal Cancer Panel, Sequencing and Deletion/Duplication** (Specific genes in this panel may be available individually. See www.aruplab.com/genetics)

Targeted testing for known mutation

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

Master Label

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