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 LYNCH SYNDROME/HNPCC TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ 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): _____

Has the patient been diagnosed with cancer? ☐ No ☐ Yes (check all that apply and specify age of onset)

☐ Colon (age[s]): _____; location(s): _____)

☐ Bladder	(age:___)	☐ Ovarian	(age:___)	☐ Sebaceous gland	(age:___)
☐ Brain	(age:___)	☐ Pancreas	(age:___)	☐ Small intestine	(age:___)
☐ Endometrial	(age:___)	☐ Rectal	(age:___)	☐ Ureter	(age:___)
☐ Gastric	(age:___)	☐ Renal pelvis	(age:___)	☐ Other: _____	(age:___)

Does the patient have polyps? ☐ No ☐ Yes (number of polyps: _____) ☐ Never scoped or unknown

Microsatellite Instability (MSI) Testing

Result by PCR: .....☐ High ☐ Low ☐ Stable ☐ Indeterminate ☐ Unknown ☐ Not performed

Result by Immunohistochemistry (IHC): .....

☐ Absent *MLH1* ☐ Absent *MSH2* ☐ Absent *MSH6* ☐ Absent *PMS2* ☐ Indeterminate ☐ Unknown ☐ Not performed

***BRAF V600E* mutation** .....☐ Positive ☐ Negative ☐ Unknown

***MLH1* methylation**.....☐ Methylated ☐ Unmethylated ☐ Indeterminate ☐ Unknown

Has germline testing for Lynch syndrome/HNPCC been previously performed <u>on the patient</u>?.....☐ No ☐ Yes ☐ Unknown

If yes, check completed test(s), provide result(s), and attach report(s).

☐ ***MLH1***: ☐ Sequencing ☐ Deletion/Duplication Result: _____

☐ ***MSH2***: ☐ Sequencing ☐ Deletion/Duplication Result: _____

☐ ***MSH6***: ☐ Sequencing ☐ Deletion/Duplication Result: _____

☐ ***PMS2***: ☐ Sequencing ☐ Deletion/Duplication Result: _____

Is there any relevant family history of colon, endometrial, ovarian, or related cancers? .....☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List the type(s) of cancer and age at diagnosis:

_____

_____

Has germline testing for Lynch syndrome/HNPCC been performed <u>for the family member(s)</u>? ☐ 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.

<u>First-tier testing options for suspected Lynch syndrome or other hereditary gastrointestinal (GI) cancer syndrome</u>:

☐ **3001605 Lynch Syndrome Panel, Sequencing and Deletion/Duplication**: Analysis of *MLH1, MSH2, MSH6, PMS2* and *EPCAM*.

☐ **2013449 Hereditary Gastrointestinal Cancer Panel, Sequencing and Deletion/Duplication**: Includes *MLH1, MSH2, MSH6, PMS2, EPCAM*, and other hereditary GI cancer and polyposis genes.

<u>Familial testing</u>

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

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

Master Label

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