ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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

HEREDITARY MYELOID NEOPLASMS AND BONE MARROW FAILURE PATIENT HISTORY FORM

Note: This testing assesses for inherited/germline DNA variants associated with hereditary predisposition to myeloid neoplasms or bone marrow failure. The preferred sample type is cultured skin fibroblasts; testing whole blood in affected patients may not definitively determine germline status.

Patient Name: _____ **Date of Birth:** _____
Sex Assigned at Birth: ☐Female ☐ Male ☐Intersex **Gender Identity (optional):** ☐Female ☐ Male ☐_____
Physician: _____ **Physician's Phone:** _____
Practice Specialty: _____ **Physician's Fax:** _____
Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity (check all that apply)
☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List countries of origin (if known): _____

Does the patient have hematological dysfunction/dysplasia? ..... ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Anemia ☐ Bone marrow failure ☐ Neutropenia
☐ Aplastic anemia ☐ Cytopenia ☐ Thrombocytopenia
☐ Beta thalassemia ☐ Macrocytosis ☐ Other: _____

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

☐ Acute lymphoblastic leukemia (ALL) ..... age:_____
☐ Acute myeloid leukemia (AML) ..... age:_____
☐ Breast cancer ..... age:_____
☐ Chronic lymphoblastic leukemia (CLL) ..... age:_____
☐ Chronic myeloid leukemia (CML) ..... age:_____
☐ Chronic myelomonocytic leukemia (CMML) ..... age:_____
☐ Hodgkin lymphoma ..... age:_____
☐ Juvenile myelomonocytic leukemia (JMML) ..... age:_____
☐ Melanoma, type:_____ age:_____
☐ Myelodysplastic syndrome (MDS) ..... age:_____
☐ Non-Hodgkin lymphoma ..... age:_____
☐ Pancreatic cancer ..... age:_____
☐ Sarcoma, location: _____ age:_____
☐ Other: _____ age:_____

Does the patient have any possible syndromic findings? ..... ☐ No ☐ Yes (check all that apply and describe) ☐ Unknown

☐ Other: _____

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

Has the patient had any DNA variant(s) identified in leukemic blood/bone marrow/tumor? ..... ☐ No ☐ Yes ☐ Unknown
If yes, describe/attach the test(s) and results: _____

Has the patient undergone previous <u>germline</u> DNA testing for hematologic or other cancers? .... ☐ No ☐ Yes ☐ Unknown
If yes, describe/attach the test(s) and results: _____

Is there any relevant family history of hematologic dysplasia and/or malignancy? ..... ☐ 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 <u>germline</u> 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).

Master Label

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