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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HEREDITARY BREAST AND OVARIAN CANCER (HBOC) TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

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: _____

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

☐ Brain ..... (age: _____)
☐ Breast ..... (age: _____)
☐ bilateral ☐ unilateral
☐ ER-/PR-/HER2- "triple negative" pathology
☐ Colon ..... (age: _____)
☐ Endometrial ..... (age: _____)
☐ Fallopian ..... (age: _____)
☐ Gastric ..... (age: _____)
☐ Kidney ..... (age: _____)
☐ Ovarian ..... (age: _____)
☐ bilateral ☐ unilateral
☐ Pancreatic ..... (age: _____)
☐ Prostate ..... (age: _____)
☐ Skin (melanoma) ..... (age: _____)
☐ Skin (non-melanoma) (age: _____)
☐ Thyroid ..... (age: _____)
☐ Other: _____ (age: _____)

Has the patient had abnormal breast imaging? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe: _____

Does this patient have a genetic variant(s) previously identified in tumor/bone marrow? ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach result(s) or describe: _____

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

Has the patient had previous germline DNA testing for *BRCA1/BRCA2* or other cancer syndrome? ☐ No ☐ Yes ☐ Unknown

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

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

If yes, specify each affected relative's relationship to the patient, symptoms, and age at diagnosis: _____

_____

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).

Check the test you intend to order:

Recommended first tier testing for suspected hereditary breast and/or ovarian cancer

☐ **2012026 Hereditary Breast and Ovarian Cancer Panel, Sequencing and Deletion/Duplication:** Multigene panel (including *BRCA1/2* genes); clinical sensitivity of >20–60% in individuals with an inherited breast and/or ovarian cancer syndrome.

☐ **2011949 Breast and Ovarian Hereditary Cancer Syndrome (*BRCA1* and *BRCA2*), Sequencing and Deletion/Duplication:** Detects >90% of pathogenic variants in *BRCA1/2* only.

☐ **2011954 Breast and Ovarian Hereditary Cancer Syndrome (*BRCA1* and *BRCA2*) Sequencing:** Detects >80% of pathogenic variants in *BRCA1/2* only.

Familial/second tier testing

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

☐ **2011915 Breast and Ovarian Hereditary Cancer Syndrome (*BRCA1* and *BRCA2*) Deletion/Duplication:** Detects ~10% of pathogenic variants in *BRCA1/2;* for patients with negative sequencing results or a known familial *BRCA1* or *BRCA2* large deletion/duplication.

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

Master Label