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 HEREDITARY BREAST AND OVARIAN CANCER (HBOC) TESTING

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

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor 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)

☐ 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 *BRCA1/2* or other cancer genes? ..... ☐ 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, describe and 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

☐ **3001855 *BRCA1* and *BRCA2*-Associated HBOC Syndrome Panel, Sequencing and Deletion/Duplication**: Detects >90% of pathogenic variants in the *BRCA1/2* genes, causative for hereditary breast and ovarian cancer (HBOC) syndrome.

☐ **2012026 Hereditary Breast and Ovarian Cancer Panel, Sequencing and Deletion/Duplication:** Multigene panel (including *BRCA1/2* genes) to confirm a diagnosis and/or family history of hereditary breast, ovarian, or related cancers.

Familial 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.

☐ **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.