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 FORM FOR HEREDITARY BREAST AND GYNECOLOGICAL CANCER

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐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)

☐ 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 allogeneic 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, endometrial, 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 variant testing):

_____

Check the test you intend to order:

Recommended testing options for suspected hereditary breast and/or gynecological cancer

☐ **3001855 *BRCA1* and *BRCA2*-Associated HBOC Syndrome Panel, Sequencing and Deletion/Duplication**: Detects >98% of pathogenic variants in the *CSDB2* and *CSDB3* genes, causative for hereditary breast and ovarian cancer (HBOC) syndrome.

☐ **2012026 Hereditary Breast and Gynecological Cancers Panel, Sequencing and Deletion/Duplication:** Multigene panel (including *CSDB203* genes) to confirm a diagnosis and/or family history of hereditary breast, gynecological, or related cancers.

Master Label

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