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.

NOONAN SPECTRUM DISORDERS TESTING PATIENT HISTORY FORM

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): _____

Patient's diagnosis: ..... ☐ Confirmed ☐ Suspected ☐ Unknown

☐ Cardiofaciocutaneous syndrome (CFCS) ☐ LEOPARD syndrome ☐ Noonan syndrome-like with loose anagen hair

☐ Costello Syndrome ☐ Noonan syndrome (NS) ☐ Other: _____

Does the patient have symptoms of a Noonan Spectrum disorder? ..... ☐ No ☐ Yes (check all that apply and describe)

Postnatal Findings

☐ Nevi, lentigines, or cafè au lait macules
☐ Intellectual disability
☐ Hearing loss
☐ Lymphatic dysplasia: _____
☐ GI: _____
☐ Malignancy: _____
☐ Coagulation disorder: _____
☐ Renal: _____
☐ Other symptom(s): _____
_____

Postnatal Findings (continued)

Dysmorphic Features
☐ Broad webbed neck
☐ Characteristic facies
☐ Cryptorchidism
☐ Curly/sparse/thin hair
☐ Low set nipples
☐ Macrocephaly
☐ Poor growth/ FTT

Postnatal Findings (continued)

Musculoskeletal
☐ Short stature
☐ Pectus excavatum/carinatum

Cardiac
☐ Pulmonary valve stenosis
☐ Hypertrophic cardiomyopathy

Perinatal Findings

☐ Cystic hygroma
☐ Hydronephrosis
☐ Increased nuchal translucency
☐ Polyhydramnios

Has the patient undergone previous testing for this condition? ..... ☐ No ☐ Yes ☐ Unknown

☐ Chromosome analysis	☐ Normal	☐ Abnormal (please attach the report)	☐ Not Performed
☐ Microarray (aCGH)	☐ Normal	☐ Abnormal (please attach the report)	☐ Not Performed

☐ Other (describe gene, method, result): _____

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

If yes, attach result or describe: _____

Is there any relevant family history? ..... ☐ 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 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).

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

Master Label