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.

HEREDITARY CANCER 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 countries of origin (if known): _____

Has the patient been diagnosed with a cancer or tumor? ☐ No ☐ Yes (Check all that apply and indicate age of diagnosis.)

☐ Adrenal (age: _____)
☐ Brain (type/age: _____)
☐ Breast (age: _____)
  ☐ bilateral ☐ unilateral
  ☐ ER-/PR-/HER2- "triple negative" pathology
☐ Colorectal (age: _____)
☐ Endometrial (age: _____)
☐ Gastric (age: _____)
☐ Leukemia (age: _____)
☐ Medullary thyroid (age: _____)
☐ Melanoma (age: _____)
☐ Nonmedullary thyroid (type/age: _____)
☐ Ovarian (age: _____)
  ☐ bilateral ☐ unilateral
☐ Pancreatic (age: _____)
☐ Parathyroid (age: _____)
☐ Pheochromocytoma (age: _____)
☐ Pituitary (age: _____)
☐ Polyposis (#/type: _____)
☐ Prostate (age: _____)
☐ Renal (age: _____)
☐ Skin (type/age: _____)
☐ Other: _____

Does the patient have additional clinical findings of a hereditary cancer syndrome? ..... ☐ 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 undergone previous DNA testing for hereditary cancer? ..... ☐ No ☐ Yes ☐ Unknown
If yes, describe the genes, method, and results: _____

Is there any relevant family history of cancers or tumors? ..... ☐ 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 mutation testing).

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

Master Label