ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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fax: 801-584-5249 | aruplab.com

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 GASTROINTESTINAL (GI) CANCER 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/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: ______________________

List countries of origin (if known): ______________________

Clinical Diagnosis: ☐ Confirmed ☐ Suspected ☐ Unknown

Does the patient have polyps? ☐ No ☐ Yes ☐ Never Scoped or Unknown

If yes, number of polyps: ______________ Location of Polyps: ☐ Colorectal ☐ Small Bowel ☐ Gastric

Polyp histopathology: ☐ Adenomatous ☐ Hamartomatous ☐ Unknown ☐ Other: ______________________

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

☐ Breast (age:______)	☐ Ovarian (age:______)	☐ Paraganglioma (age:______)
☐ Colon (age:______)	☐ Pancreatic (age:______)	☐ Renal (age:______)
☐ Endometrial (age:______)	☐ Pheochomocytoma (age:______)	☐ Rectal (age:______)
☐ Gastric (age:______)		☐ Thyroid (age:______)

☐ Other: ______________________ (age:______)

Does the patient have additional clinical findings (i.e. cutaneous, GI, musculoskeletal/neurological, or vascular)? ☐ No ☐ Yes

If yes, describe: ______________________

Has the patient undergone previous tumor IHC or MSI testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the <u>results</u>: ______________________

Has the patient undergone previous DNA testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the <u>genes</u>, <u>methodology</u>, and <u>results</u>: ______________________

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

Is there any relevant <u>family history</u> of gastrointestinal or other cancers? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's <u>relationship</u> to the patient. List their <u>symptoms</u> and <u>age of onset</u>: ______________________

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 assistance with test selection when a relative has been tested previously, please contact an ARUP Genetic Counselor at 800-242-2787 ext. 2141

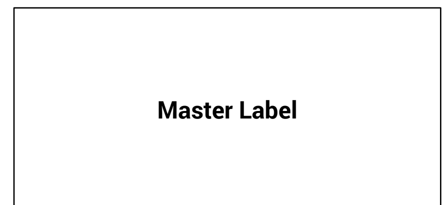
Check the test you intend to order:

<u>Multi-gene panel testing for hereditary gastrointestinal cancer syndromes</u>

☐ **2013449 Hereditary Gastrointestinal Cancer Panel, Sequencing and Deletion/Duplication** Specific genes in this panel may be available individually. See aruplab.com/genetics

<u>Targeted testing for known mutation</u>

☐ **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.



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