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 *PTEN* HAMARTOMA TUMOR SYNDROME (PHTS) 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): _____

Clinical Diagnosis/Reason for Referral:

☐ Bannayan-Riley-Ruvalcaba syndrome ☐ Intellectual disability/autism ☐ Proteus-like syndrome
☐ Cowden syndrome ☐ Proteus syndrome ☐ Other: _____

Does the patient have symptoms? ..... ☐ No ☐ Yes (check all that apply and describe)

☐ Breast cancer..... (age: _____)
☐ Endometrial cancer..... (age: _____)
☐ Follicular thyroid cancer ..... (age: _____)
☐ Intellectual disability / developmental delay
☐ Keratoses (location: _____)
☐ Lhermitte-Duclos disease (cerebellar tumor)
☐ Lipomas
☐ Macrocephaly
☐ Nevi ..... (☐ connective tissue ☐ epidermal)
☐ Papillary thyroid cancer ..... (age: _____)
☐ Papillomatous papules
☐ Pigmented macules of glans penis
☐ Tissue overgrowth
☐ Trichilemmomas
☐ GI hamartoma (describe) location: _____ number: _____
☐ Skeletal abnormalities (describe): _____
☐ Vascular malformation (describe): _____
☐ Other symptom(s): _____

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

Has the patient undergone previous DNA testing ..... ☐ No ☐ Yes ☐ Unknown
If yes, describe the test(s) and results: _____

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 mutation testing).

Check the test you intend to order.

☐ **2002470 *PTEN*–Related Disorders, Sequencing and Deletion/Duplication:** Sequencing and deletion/duplication analysis of *PTEN* coding regions and intron/exon boundaries with a clinical sensitivity of 85% for Cowden, 65% for Bannayan-Riley-Ruvalcaba, and 20% for Proteus syndrome.

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; a copy of 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.