ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR *PTEN* HAMARTOMA TUMOR SYNDROME (PHTS) TESTING

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

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.

☐ **2002722 *PTEN*-Related Disorders (*PTEN*) Sequencing**

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

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

Master Label