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.

VON HIPPEL-LINDAU SYNDROME/CONGENITAL POLYCYTHEMIA (VHL) TESTING PATIENT HISTORY FORM

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): _____

Does the patient have symptoms of VHL syndrome? ..... ☐ No ☐ Yes (check all that apply)

☐ Cerebellar hemangioblastoma ☐ Endolymphatic sac tumor ☐ Retinal hemangioblastoma
☐ Clear cell renal carcinoma ☐ Pheochromocytoma ☐ Spinal hemangioblastoma
☐ Other symptom(s): _____

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

☐ Headache ☐ Plethora ☐ Thrombotic/vascular event (describe: _____)

Are the laboratory findings suggestive of polycythemia? ..... ☐ No ☐ Yes (describe below) ☐ Unknown

Hematocrit: _____% Hemoglobin concentration: _____g/Dl

Erythropoietin_____U/mL Red blood cells: _____x10¦ 6/λL

Other: _____

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, specify: ..... ☐ VHL ☐ Polycythemia ☐ Neither ☐ Unknown

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.

☐ **2002965 von Hippel-Lindau (VHL) Sequencing and Deletion/Duplication:** Sequencing and deletion/duplication analysis of the VHL gene with a clinical sensitivity of 99% for VHL syndrome. Please do not order for congenital polycythemia as large deletions/duplications have not been reported as causative.

☐ **2002970 von Hippel-Lindau (VHL) Sequencing:** Sequencing of VHL coding regions and intron/exon boundaries with a clinical sensitivity of 89% for VHL syndrome and ~20% for congenital polycythemia.

☐ **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.