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 *APC*- ASSOCIATED POLYPOSIS CONDITIONS AND *MUTYH*- ASSOCIATED POLYPOSIS TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ 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 country of origin (if known): _____

Does the patient have symptoms? ..... ☐ No ☐ Yes (indicate the clinical diagnosis)

Does the patient have polyps? ..... ☐ No ☐ Yes ☐ Never scoped ☐ Unknown

If yes, indicate the following:

Number of polyps: ..... ☐ <10 ☐ 10-49 ☐ 50-99 ☐ 100-500 ☐ >500

Location(s):..... ☐ Colon ☐ Gastric ☐ Duodenal

Has histopathology confirmed that the polyps are adenomatous?..... ☐ No ☐ Yes ☐ Unknown ☐ NA

Has the patient been diagnosed with cancer? ..... ☐ No ☐ Yes (check all that apply and indicate age at diagnosis)

☐ Colon (age: _____) ☐ Hepatoblastoma (age: _____) ☐ Rectal (age: _____)

☐ Gastric (age: _____) ☐ Medulloblastoma (age: _____) ☐ Thyroid (age: _____)

☐ Other: _____ (age:_____)

Are there other clinical manifestations? (check all that apply)

☐ CHRPE ☐ Desmoid tumors ☐ Epidermoid cysts ☐ Osteomas ☐ Other: _____

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

Has the patient undergone previous DNA testing for *APC*- or *MUTYH*- associated polyposis? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

Is there any relevant family history of cancer or polyposis? ..... ☐ 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.

☐ **3004407 *APC*- and *MUTYH*-Associated Polyposis Panel, Sequencing and Deletion/Duplication:** Analysis of the *APC* and *MUTYH* genes. Clinical sensitivity is ~93% for FAP and ~99% for MAP.

☐ **2013449 Hereditary GI Cancer Panel, Sequencing and Deletion/Duplication:** Multigene panel (including *APC*, *MUTYH*, and others) for individuals with a personal or family history of GI cancer and/or polyposis.

☐ **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.