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 TUBEROUS SCLEROSIS COMPLEX PANEL, SEQUENCING AND DELETION/DUPLICATION

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 a diagnosis of Tuberous Sclerosis Complex (TSC)? ☐ Confirmed ☐ Suspected ☐ Unknown

Does the patient have clinical symptoms? ☐No ☐ Yes (check all that apply) ☐ Unknown

☐ Skin
- ☐ Hypomelanotic macules (#_____)
- ☐ Confetti skin lesions
- ☐ Facial angiofibromas (#_____)
- ☐ Shagreen patch
- ☐ Ungula fibromas (#_____)

☐ Central Nervous System
- ☐Subependymal nodules
- ☐Cortical dysplasias
- ☐ Subependymal giant cell astrocytoma
- ☐Seizures

☐ **Other symptom(s):** _____

- ☐ Cognitive impairment (specify:_____)
- ☐ Renal angiomyolipoma
- ☐ Renal cysts (#_____)
- ☐ Cardiac rhabdomyoma
- ☐ Pulmonary lymphangioleiomyomatosis (LAM)
- ☐ Retinal hamartomas
- ☐ Retinal achromic patches

Does the patient have a FAMILY HISTORY of TSC or individuals with findings of TSC? ☐ No ☐ Yes ☐ Unknown

If yes, attach a PEDIGREE or specify the relatives' RELATIONSHIP to the patient. List their symptoms & age of onset:

Has DNA testing been performed for these family member(s)? ☐ **No** ☐ **Yes** ☐ **Unknown**

Has the patient undergone previous DNA testing for TSC? ☐ **No** ☐ **Yes** ☐ **Unknown**
If yes, please describe test(s) and results: _____

Check the test you intend to order OR write the test name and number below:

Testing for Tuberous Sclerosis Complex

☐ 3002100 Tuberous Sclerosis Complex Panel, Sequencing and Deletion/Duplication: NGS and CGH of *TSC1* and *TSC2*.

☐ 2001961 Familial Mutation, Targeted Sequencing: Targeted testing for a known familial sequence variant; a copy of the affected relative's lab report is REQUIRED.

Prenatal Testing for Tuberous Sclerosis Complex:

☐ 3002096 Tuberous Sclerosis Complex Panel, Sequencing and Deletion/Duplication, Fetal: NGS and CGH of *TSC1* and *TSC2* on cultured fetal samples (cultured villi or amniocytes).

☐ 2001980 Familial Mutation, Targeted Sequencing, Fetal: Targeted testing for a known familial sequence variant on a fetal sample; a copy of the affected relative's lab report is REQUIRED.

Master Label

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