ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform hereditary gastrointestinal cancer testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HEREDITARY GASTROINTESTINAL CANCER TESTING

Patient Name ____ **Date of Birth** ______/______/ ______**Gender [ ] F [ ] M**

Physician ___________________________________**Physician Phone (**_____**)** _______________ **Practice Specialty** ________

Genetic Counselor________________________________ **Counselor Phone (**_______**)** _______________________

Patient's ETHNICITY (check all that apply)
[ ] African American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other ____________________

Does patient have CLINICAL FINDINGS? [ ] No [ ] Yes.
If yes, fill out information below OR send a copy of a recent clinic note outlining patient's clinical findings and relevant testing results.

Patient's diagnosis: ____ [ ] Confirmed [ ] Suspected [ ] Unknown

Does the patient have polyps? [ ] No [ ] Yes [ ] Never Scoped or Unknown
If yes, number of polyps: ___________ Location of polyps: [ ] Colorectal [ ] Small Bowel [ ] Gastric
Polyp histopathology: [ ] Adenomatous [ ] Hamartomatous [ ] Unknown [ ] Other: _________________________

Has the patient been diagnosed with cancer? [ ] No [ ] Yes, check all that apply and describe
[ ] Breast (age_____) [ ] Ovarian (age_____) [ ] Renal (age_____)
[ ] Colon (age_____) [ ] Pancreatic (age_____) [ ] Rectal (age_____)
[ ] Endometrial (age_____) [ ] Pheochromocytoma (age_____) [ ] Thyroid (age_____)
[ ] Gastric (age_____) [ ] Paraganglioma (age_____) [ ] Other:______________ (age____)

Does the patient have additional clinical findings? [ ] No [ ] Yes If yes, please check all that apply and describe:
[ ] Cutaneous: ____
[ ] Gastrointestinal: ____
[ ] Musculoskeletal/Neurological: ____
[ ] Vascular: ____
[ ] Other: ____

Has the patient undergone previous tumor IHC or MSI testing? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the results____

Has the patient undergone previous DNA testing? [ ] No [ ] Yes [ ] Unknown
Gene___________________ Method____ Result____________________________________

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

Does the patient have a FAMILY HISTORY of gastrointestinal cancers? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the relatives RELATIONSHIP to the patient, symptoms, and age of onset. ________________________
____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Circle the test you intend to order:

Recommended first tier testing for hereditary gastrointestinal cancer syndromes	
2013449	**Gastrointestinal Hereditary Cancer Panel, Sequencing and Deletion/Duplication, 16 Genes** (specific genes in this panel may be available individually. See www.aruplab.com/genetics)
Targeted testing for a known mutation (laboratory report from family member REQUIRED)	
2001961	**Familial Mutation, Targeted Sequencing**. Targeted testing for a known pathogenic familial sequence variant.

Other test not listed: ____

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

Master Label