

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

**PATIENT HISTORY FOR FAMILIAL ADENOMATOUS POLYPOSIS TESTING**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  F  M

Physician \_\_\_\_\_ Physician Phone (\_\_\_\_) \_\_\_\_\_ Practice Specialty \_\_\_\_\_

Genetic Counselor \_\_\_\_\_ Counselor Phone (\_\_\_\_) \_\_\_\_\_

**Patient's Ethnicity** (check all that apply)

- |   |   |  |                                      |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian           | <input type="checkbox"/> Caucasian   |
| <input type="checkbox"/> Hispanic         | <input type="checkbox"/> Middle Eastern   | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

**Does the patient have symptoms?**  Yes  No  Unknown

**If yes, what is the patient's clinical diagnosis?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> FAP             | <input type="checkbox"/> Attenuated FAP   | <input type="checkbox"/> MUTYH-associated polyposis (MAP) |
| <input type="checkbox"/> Turcot Syndrome | <input type="checkbox"/> Gardner Syndrome | <input type="checkbox"/> Other _____                      |

**Does the patient have polyps?**  Yes  No  Never Scoped  Unknown

If yes, 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

**If yes, check all that apply:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Colon (age _____)   | <input type="checkbox"/> Hepatoblastoma (age _____) | <input type="checkbox"/> Medulloblastoma (age _____) |
| <input type="checkbox"/> Gastric (age _____) | <input type="checkbox"/> Thyroid (age _____)        |  |
| <input type="checkbox"/> Rectal (age _____)  | <input type="checkbox"/> Other _____ (age _____)    |  |

**Other clinical manifestations?**

- CHRPE  Desmoid tumors  Epidermoid cysts  Osteomas

**Has the patient undergone previous DNA testing for FAP/Polyposis?**  No  Yes

If yes, please describe test(s) and results \_\_\_\_\_

**Does the patient have a FAMILY HISTORY of FAP/Polyposis?**  No  Yes  Unknown

If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic/affected relative. \_\_\_\_\_

**Please attach a copy of the PEDIGREE and a relative's DNA laboratory result.**

**Circle the test you intend to order.**

**2004915 Familial Adenomatous Polyposis Panel:** *APC* Sequencing, *APC* Deletion/Duplication, and *MYH* 2 Mutations

**2004863 Familial Adenomatous Polyposis (*APC*) Sequencing**

**2004911 *MYH*-Associated Polyposis (*MYH*) 2 Mutations**

**2004920 Familial Adenomatous Polyposis (*APC*) Deletion/Duplication.** For patients with negative *APC* sequencing result. Clinical sensitivity ~8-12%. **Also order for familial *APC* large deletion or duplication testing.**

**2001961 Familial Mutation, Targeted Sequencing.** Tests for an *APC* sequence change identified in a family member. A copy of relative's DNA laboratory result is REQUIRED.

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

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