

Molecular Genetics – Inherited Cancer Syndromes Patient Information Sheet

The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, please supply the information requested below and **send paperwork with the specimen or return by fax to Laboratory Genetics 507-284-0670 (phone 507-538-2996).**

Name of Patient (Last, First, Middle)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (mm/dd/yyyy)
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Check box(es) below and complete information to indicate who should receive reports.

<input type="checkbox"/> Requesting Physician	Phone Number	Fax Number
<input type="checkbox"/> Genetic Counselor	Phone Number	Fax Number
MML Account Number		

Reason for Testing NOTE: It is recommended to first document a mutation in an affected family member prior to performing pre-symptomatic testing.

<input type="checkbox"/> Patient has a definite diagnosis of	<input type="checkbox"/> FAP <input type="checkbox"/> HNPCC <input type="checkbox"/> MEN2 <input type="checkbox"/> MYH	Age when diagnosed _____
<input type="checkbox"/> Patient has a possible diagnosis of	<input type="checkbox"/> FAP <input type="checkbox"/> HNPCC <input type="checkbox"/> MEN2 <input type="checkbox"/> MYH	
<input type="checkbox"/> Patient is asymptomatic but has a family history of	<input type="checkbox"/> FAP <input type="checkbox"/> HNPCC <input type="checkbox"/> MEN2 <input type="checkbox"/> MYH	

Family History

Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:
Are other relatives known to be a carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient:
Have other relatives had molecular genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the results (specific mutation(s) identified and the laboratory at which testing was performed):

If the relative was tested at the Mayo Clinic, include the name of the family member:

Please include a detailed pedigree, if available.

FAP (Familial Adenomatous Polyposis)

MYH (MYH Gene Analysis for Multiple Adenoma Clinical Information)

<p>NUMBER OF POLYPS</p> <input type="checkbox"/> Not screened <input type="checkbox"/> Screen negative (0 polyps) <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-100 <input type="checkbox"/> 101-500 <input type="checkbox"/> > 500 Has histopathology confirmed that polyps are adenomatous? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>OTHER CLINICAL MANIFESTATIONS</p> CHRPE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Desmoid tumors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Epidermoid cysts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Osteomas <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Duodenal or gastric polyps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Colon cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Please list location of Colon Cancer: Other - please describe:
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HNPCC (Hereditary Nonpolyposis Colorectal Cancer)

<p>NUMBER OF POLYPS</p> <input type="checkbox"/> Not screened <input type="checkbox"/> Screen negative (0 polyps) <input type="checkbox"/> List number of polyps present:	<p>OTHER CLINICAL MANIFESTATIONS</p> Endometrial Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Gastric Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Upper Tract Urothelial Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Brain tumor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Colon cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Please list location of Colon Cancer: Other - please describe:
Has MSI and/or IHC been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate results:	

MEN2 (Multiple Endocrine Neoplasia Type 2)

CLINICAL SYMPTOMS (in this individual)		
<input type="checkbox"/> Medullary Thyroid Cancer	<input type="checkbox"/> Elevated Calcitonin	<input type="checkbox"/> Pheochromocytoma
<input type="checkbox"/> Ganglioneuromas	<input type="checkbox"/> Hyperparathyroidism	<input type="checkbox"/> Other: _____