

**THIS IS NOT A TEST REQUEST FORM.**  
**The information below is required to perform Multiple Endocrine Neoplasia Type 1 (MEN1), Gene testing.**  
**Please fill out this form and submit it with the test request form or electronic packing list.**

**PATIENT HISTORY FOR MULTIPLE ENDOCRINE NEOPLASIA TYPE 1 (MEN1) GENE 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 a diagnosis of MEN1?**  Confirmed  Suspected  Unknown

**Does the patient have SYMPTOMS?**  No  Yes, check all that apply

**Endocrine tumor**

- Parathyroid
- Pituitary
- Gastro-entero-pancreatic (GEP):
- Gastrinoma
- Insulinoma
- Glucagonoma
- VIPoma
- Other: \_\_\_\_\_

**Non-endocrine tumor**

- Facial angiofibroma
- Collagenoma
- Lipoma
- Ependymoma
- Leiomyoma
- Meningioma
- Other: \_\_\_\_\_

**Laboratory findings**

- |              |                                   |                                 |
|--------------|-----------------------------------|---------------------------------|
| Parathyroid: | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Calcium:     | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Prolactin:   | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Gastrin:     | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Cortisol:    | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Insulin:     | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Proinsulin   | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| C-peptide    | <input type="checkbox"/> Elevated | <input type="checkbox"/> Normal |
| Other:       | _____                             |                                 |

**Does the patient have a FAMILY HISTORY of MEN1 or related findings?**  No  Yes  Unknown

If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family members(s) to the patient and detail the symptoms/age of onset in each symptomatic relative.

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

If yes, attach copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

**Has the patient undergone previous DNA testing?**  No  Yes  Unknown

If yes, please describe the gene/disorder, methodology, and results \_\_\_\_\_

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

**2005360 Multiple Endocrine Neoplasia Type 1 (MEN1), Sequencing and Deletion/Duplication;** Sequence analysis and MLPA of *MEN1* coding regions; clinical sensitivity approaches 94%.

**2005359 Multiple Endocrine Neoplasia Type 1 (MEN1), Sequencing;** Sequence analysis of *MEN1* coding regions; clinical sensitivity approaches 90%.

**2005346 Multiple Endocrine Neoplasia Type 1 (MEN1), Deletion/Duplication;** MLPA of *MEN1* coding regions; clinical sensitivity approaches 4%.

**2001961 Familial Mutation, Targeted Sequencing;** Tests for a *MEN1* sequence change identified in a family member; copy of relative's lab result is REQUIRED.

**2001961 Familial Mutation, Targeted Sequencing**

Tests for a *RET* sequence change previously identified in a family member; copy of relative's lab result is REQUIRED.

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

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