

**THIS IS NOT A TEST REQUEST FORM.**  
**The information below is required to perform Multiple Endocrine Neoplasia 2, *RET* 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 2, *RET* 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 MEN2?**  Confirmed  Suspected  Unknown

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

- Medullary thyroid carcinoma (MTC) ( Bilateral/ Unilateral,  Monoclonal/ Multifocal, Age of onset: \_\_\_\_\_)
- Pheochromocytoma ( Bilateral  Unilateral, Age of onset: \_\_\_\_\_)
- Hyperparathyroidism (Age of onset: \_\_\_\_\_)
- Parathyroid hyperplasia (Age of onset: \_\_\_\_\_)
- Parathyroid adenoma (Age of onset: \_\_\_\_\_)
- Skeletal abnormalities (describe: \_\_\_\_\_)
- Eye abnormalities (describe: \_\_\_\_\_)
- Neuromas (describe: \_\_\_\_\_)
- Hirschsprung disease
- Other \_\_\_\_\_

**Laboratory Findings**

- |                     |                                   |                                 |                                  |
|---------------------|-----------------------------------|---------------------------------|----------------------------------|
| Calcitonin          | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Calcium             | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Parathyroid Hormone | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |
| Catecholamines      | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Unknown |

Does the patient have a **FAMILY HISTORY** of MEN2 or related findings?  No  Yes  Unknown  
 If yes, specify the **RELATIONSHIP** of the affected family member(s) to the patient and detail the symptoms/age of onset in each.

\_\_\_\_\_

Please attach a copy of the relative's *RET* laboratory result (REQUIRED for familial mutation testing)

**Circle the MULTIPLE ENDOCRINE NEOPLASIA 2 (*RET*) test you intend to order.**

**0051390 Multiple Endocrine Neoplasia Type 2 (MEN2), *RET* Gene Mutations by Sequencing**

Sequencing of *RET* exons 10, 11, 13-16 with 95%, 88%, and 98% clinical sensitivity for MEN2A, Familial Medullary Thyroid Carcinoma, and MEN2B respectively. Order for individuals with MTC and/or other findings suggestive of MEN2.

**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**

Master Label