ARUP LABORATORIES

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

PATIENT HISTORY FOR PANCREATITIS 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 the patient have SYMPTOMS? [ ] No [ ] Yes (check all that apply)

[ ] Abdominal Pain [ ] Oily stools [ ] Malabsorption/Weight loss
[ ] Diarrhea [ ] Nausea and Vomiting [ ] Elevated Amylase and Lipase
[ ] Diabetes [ ] Other ______________________________

PATIENT'S DIAGNOSIS

[ ] Unknown [ ] Chronic Pancreatitis [ ] Hereditary Pancreatitis
[ ] Acute Pancreatitis [ ] Recurrent Pancreatitis [ ] Other__________________________________

PATIENT RISK FACTORS FOR PANCREATITIS? (Check all that apply)

[ ] None (idiopathic) [ ] Gall stones [ ] Infection___________________________________
[ ] Heavy alcohol use [ ] Hyperlipidemia [ ] Medication_________________________________
[ ] Hypercalcemia [ ] Abdominal Trauma [ ] Autoimmune ________________________________
[ ] Smoking [ ] Other____

Does the patient have a FAMILY HISTORY of [ ] Pancreatitis [ ] Cystic Fibrosis [ ] Neither [ ] 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)? [ ] Yes [ ] No [ ] Unknown
If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for [ ] Pancreatitis [ ] Cystic Fibrosis [ ] Neither [ ] Unknown
If yes, please describe test(s) and results____

Circle the Pancreatitis test you intend to order.

2002005 Pancreatitis, Idiopathic (CFTR, PRSS1 & SPINK1) Sequencing Clinical sensitivity for idiopathic pancreatitis of 45% and hereditary pancreatitis of 80%.

2002016 Pancreatitis, Hereditary (PRSS1) Sequencing Clinical sensitivity for hereditary pancreatitis of 80% and 10% for idiopathic pancreatitis.

2002012 Pancreatitis, Idiopathic (SPINK1) Sequencing Clinical sensitivity for idiopathic pancreatitis of 15%.

2001961 Familial Mutation, Targeted Sequencing: Tests for the specific mutation identified in a family member. A copy of the relative's DNA lab result is REQUIRED for this test.

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

Master Label