



Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen.**

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact <i>(Last, First)</i>	Phone	Fax*

*Fax number provided must be from a fax machine that complies with applicable HIPAA regulations.

Purpose of Study Check all that apply.

Clinical Status: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic
Study Purpose: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Presymptomatic
Note: If testing for a previously identified familial VHL mutation or variant is desired, order test FMTT / Familial Mutation, Targeted Testing, Varies and provide documentation of the familial mutation or variant to the laboratory by attaching a copy of the genetic test lab report and filling in the familial mutation or variant below.
<ul style="list-style-type: none"> • Mutation or variant to be detected: _____ • Proband's relationship to the patient: _____

Pertinent Clinical and Laboratory History Check all that apply.

Renal cysts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Renal tumors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pheochromocytomas <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If known, list number and/or location: _____	Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Endolymphatic sac tumors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pancreatic cysts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pancreatic tumors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Epididymal or broad ligament tumors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Hemangioblastomas <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If known, indicate location and/or number: <input type="checkbox"/> Brain <input type="checkbox"/> Spinal cord <input type="checkbox"/> Retina <input type="checkbox"/> Other: _____	
Other Relevant Clinical Information (surgeries, etc.)	

Ethnic Background Ethnic background is necessary to provide appropriate interpretation of test results.

<input type="checkbox"/> Northern European Caucasian	<input type="checkbox"/> Mixed European Caucasian	<input type="checkbox"/> Southern European Caucasian	<input type="checkbox"/> African American
<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other, specify: _____			

Family History Include a detailed pedigree, if available.

Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate their relationship to the patient: _____
Have other relatives had molecular genetic testing for VHL? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate the performing laboratory and attach a copy of the genetic test lab report if available: _____
If the relative was tested at Mayo Clinic, include the name of the family member: _____