



Hereditary Paraganglioma Patient Information

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IMPRINT PATIENT IDENTIFICATION PLATE HERE

Instructions:

1. In order to provide you with better service, please complete **all** information as requested. Type or print **clearly**.
2. Include this form (or copy) with specimen and requisition form.
3. Please attach a **clinical summary, family history** and **pedigree** (Pedigree can be in comments section or on a separate sheet).

Patient Identification:

Name: _____ SS#: _____ Sex: M F Birthdate: _____
 Ordering Facility: _____
 Requesting Physician/Health Care Professional (HCP) Name (Required): _____
 Physician/HCP Address: _____ Phone#: () _____
 _____ FAX# () _____

Patient Medical History

YES NO

Does this patient have a diagnosis of Paraganglioma or Pheochromocytoma? Age at diagnosis _____
 Location of tumor(s): _____

Was the tumor hormonally active (functioning)? Symptoms: _____
 Benign / Malignant (Please circle)

Has this patient had clinical or research genetic testing for hereditary paraganglioma syndromes at another laboratory? Which laboratory? If yes, which gene(s):
 Negative Positive
 (if more than one gene please list in comments section) Specific mutation: _____

Family History:

Have family members of this patient been diagnosed with a Paraganglioma or Pheochromocytoma?

Please provide family relationship, location of tumor and age at diagnosis for each affected family member (can be in pedigree):

Have any patient's relatives had genetic testing for hereditary paraganglioma / pheochromocytoma syndromes? If yes, which gene(s):
 Negative Positive
 (if more than one gene please list in comments section) Specific mutation: _____

Comments: