

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, please supply the information requested below and **send paperwork with the specimen.**

Patient Information

Patient Name (First, Middle Initial, Last)		Birth Date (Month DD, YYYY)	Sex
Referring Physician Name	Phone Number	Fax Number*	
Other Contact	Phone Number	Fax Number*	

* Fax number given must be from a fax machine that complies with applicable HIPAA regulation.

Clinical Status:	<input type="checkbox"/> Symptomatic	<input type="checkbox"/> Asymptomatic
Purpose of Study:	<input type="checkbox"/> Diagnostic	<input type="checkbox"/> Presymptomatic

VHL Known Mutation (if applicable)

If 89084 VHL Known Mutation is ordered, the following information must be provided or testing cannot be completed:

Known familial mutation to be detected:
 Proband's relationship to patient:

VHL Deletion Detection (if applicable)

If 89211 VHL Deletion Detection is ordered, please provide the following information

Familial deletion (if known):
 Proband's relationship to patient:

Clinical History (check all that apply)

Pertinent Clinical and Laboratory History		
Hemangioblastoma(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If known, please indicate location and/or number:	<input type="checkbox"/> Brain:	<input type="checkbox"/> Spinal cord: <input type="checkbox"/> Retina: <input type="checkbox"/> Other:
Renal cyst(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Renal tumor(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pheochromocytoma(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If known, please list number and/or location:		
Endolymphatic sac tumor(s)?	<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 cyst(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pancreatic tumor(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Epididymal or broad ligament tumor(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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
Caucasian- Please indicate countries of origin:		
<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian
<input type="checkbox"/> French Canadian	<input type="checkbox"/> African American	<input type="checkbox"/> Other (specify):
Family History		
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, please 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:		
Please attach a detailed pedigree, if available.		