

**MEDICAL GENOMICS LABORATORY**

720 Twentieth Street South, Suite 330
Birmingham, Alabama 35294-0005

Phone: (205) 934-5562
Fax: (205) 996-2929

www.uab.edu/medicine/genetics/medical-genomics-laboratory

UAB MGL
Accession

For MGL Lab Use Only	Received:	Reviewed:	Accession:	Billing:	Other:
	Initials:				
	Date:				
	Comment:				

Important Notes

-This form must accompany all specimens received

-Billing information (page 5) must be included

-All specimens received must include **two** patient identifiers and **collection date**

-Testing must be ordered by a qualified clinician

Additional information is available online at www.uab.edu/medicine/genetics/medical-genomics-laboratory

Test Requisition Form

Patient Information:			Ordering Physician:		
Sample Collected: (MM/DD/YY)			<input type="checkbox"/> Please check box if physician should receive report directly Name: _____ NPI: _____ Institution: _____		
Name: (First) (MI) (Last)					
DOB: (MM/DD/YY)	MRN:		Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Country:	Phone:	
Gender:	SSN:		<input type="checkbox"/> Please check preferred result delivery: <input type="checkbox"/> Email:	<input type="checkbox"/> Fax: _____	
Parent or Guardian name (if minor):					
Referring Lab/Hospital:			Additional Reports to:		
<input type="checkbox"/> Please check box if lab/hospital should receive report directly Name: _____ Institution: _____ Address: _____ City: _____ State: _____ Zip: _____ Country: _____ Phone: _____ Please check preferred result delivery: <input type="checkbox"/> Fax: <input type="checkbox"/> Email:			Name: _____ Institution: _____ Address: _____ City: _____ State: _____ Zip: _____ Country: _____ Phone: _____ <input type="checkbox"/> Please check preferred result delivery: <input type="checkbox"/> Fax: <input type="checkbox"/> Email:		

Previous Testing History

Check all that apply:	<input type="checkbox"/> Patient or family member is pregnant. LMP:	<input type="checkbox"/> Patient has had chemotherapy in the past 6 months
	<input type="checkbox"/> Patient has had a bone marrow transplant	<input type="checkbox"/> Infectious diseases (AIDS, Hepatitis, etc.)

Has this patient or relatives had previous testing? Yes No

Name/Relationship to patient:	Test/Variant/Lab:
Name/Relationship to patient:	Test/Variant/Lab:

Informed Consent

Provider's statement: I acknowledge the risks, benefits, limitations, and implications of genetic testing as outlined on the complete informed consent handout; and I have discussed the test(s) requested with the patient/guardian and I have answered his/her questions regarding testing. Informed consent has been obtained from the patient/guardian and the hard copy will be maintained.

Provider's Signature: _____



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Name: (First) (MI) (Last) DOB: (MM/DD/YY)

Lymphocyte/White Blood Cell-based Comprehensive Testing via Next-Gen Sequencing

RUSH Analysis: Testing completed within **15 working days** of receipt of sample
 (Additional **\$600 RUSH fee** applied; only available for tests on this page)

NF1/Legius syndrome and Other RASopathy Related Conditions		NF2/Schwannomatosis/Meningiomatosis
<input type="checkbox"/> NF1-NG: NGS and Del/Dup: <i>NF1</i> only		<input type="checkbox"/> NF2-NG: NGS and Del/Dup: <i>NF2</i> only
<input type="checkbox"/> NFSP-NG: NGS and Del/Dup: <i>NF1</i> and <i>SPRED1</i>		<input type="checkbox"/> SCH-NG: NGS: 3 genes: <i>LZTR1</i> , <i>NF2</i> , and <i>SMARCB1</i> ; and Del/Dup: <i>NF2</i> , <i>LZTR1</i> , and <i>SMARCB1</i>
<input type="checkbox"/> NNP-NG: NGS: 17 genes (no NF1): <i>BRAF</i> , <i>CBL</i> , <i>HRAS</i> , <i>KRAS</i> , <i>LZTR1</i> , <i>MAP2K1</i> , <i>MAP2K2</i> , <i>NRAS</i> , <i>PPP1CB</i> , <i>PTPN11</i> , <i>RAF1</i> , <i>RASA2</i> , <i>RIT1</i> , <i>SHOC2</i> , <i>SOS1</i> , <i>SOS2</i> , and <i>SPRED1</i> ; and Del/Dup: <i>SPRED1</i> and <i>LZTR1</i>		<input type="checkbox"/> MEN-NG: NGS: 4 genes: <i>NF2</i> , <i>SMARCB1</i> , <i>SMARCE1</i> , and <i>SUFU</i> ; and Del/Dup: <i>NF2</i> and <i>SMARCB1</i>
<input type="checkbox"/> RAS-NG: NGS: 18 genes: <i>BRAF</i> , <i>CBL</i> , <i>HRAS</i> , <i>KRAS</i> , <i>LZTR1</i> , <i>MAP2K1</i> , <i>MAP2K2</i> , <i>NF1</i> , <i>NRAS</i> , <i>PPP1CB</i> , <i>PTPN11</i> , <i>RAF1</i> , <i>RASA2</i> , <i>RIT1</i> , <i>SHOC2</i> , <i>SOS1</i> , <i>SOS2</i> , and <i>SPRED1</i> ; and Del/Dup: <i>NF1</i> , <i>SPRED1</i> , and <i>LZTR1</i>		Peripheral Nerve Sheath Tumor Testing
<input type="checkbox"/> CST-NG: NGS: <i>HRAS</i> only		<input type="checkbox"/> PNT-NG: NGS: 6 genes: <i>NF1</i> , <i>NF2</i> , <i>KRAS</i> , <i>LZTR1</i> , <i>PTPN11</i> and <i>SMARCB1</i> ; and Del/Dup: <i>NF1</i> , <i>NF2</i> , <i>LZTR1</i> , and <i>SMARCB1</i>
McCune-Albright Syndrome		Rhabdoid Tumor Predisposition Syndrome
<input type="checkbox"/> GNAS-NG: NGS: <i>GNAS</i> exons 8 and 9 only		<input type="checkbox"/> RT-NG: NGS: <i>SMARCB1</i> and <i>SMARCA4</i> ; and Del/Dup: <i>SMARCB1</i> only
Tuberous Sclerosis Complex		Capillary Malformation Arteriovenous Malformation Syndrome
<input type="checkbox"/> TSCP-NG: NGS and Del/Dup: <i>TSC1</i> and <i>TSC2</i>		<input type="checkbox"/> RASA-NG: NGS: <i>RASA1</i> and <i>EPHB4</i> ; and Del/Dup: <i>RASA1</i> only

Additional Information
Test Description Key:

Next Generation Sequencing (NGS)
 Deletion/Duplication analysis (Del/Dup)

For additional testing options via **tumor/biopsy**, please see **page 3** of this order form.
 Please contact the lab via phone (205) 934-5562 or via email at medgenomics@uabmc.edu if you have any questions when completing this form.
 For additional information, visit our website at www.uab.edu/medicine/genetics/medical-genomics-laboratory

Important points of consideration for testing

The average coverage for all of our panels is >1800x. Specifically for the *NF1* gene, the NGS approach covers >98.5% of the *NF1* coding region at $\geq 350X$ and 99.9% $\geq 200X$, allowing detection of very low level mosaicism, down to 3-5% variant allele fraction respectively. For all other genes on our panels, the NGS approach covers an average of 99% at $\geq 200X$. Remaining regions are covered at $\geq 30X$. However, for patients with segmental/mosaic presentation, deep coverage in lymphocyte cells may be insufficient to identify the underlying gene change. Testing the affected tissue(s) may be necessary to confirm a diagnosis. Please see page 3 for our tumor/biopsy-based testing options.

Please note: For patients with an ongoing pregnancy who require comprehensive *NF1* testing, "NF1-R" is recommended due to the sensitivity and fast turnaround time of this test (please see page 4 for this option).

Specimen Requirements

Accepted Specimens	Specimen Information:
<p>Specimen requirements vary based on test requested; please see our website for more details.</p> <p>-Blood: 3-6ml EDTA (receipt within one week of collection)</p> <p>-Saliva: OGR-575 DNA Genotek (kits are provided upon request)</p> <p>-DNA: extracted from lymphocyte cells, a minimum of 25ul at 3μg, O.D. value at 260:280nm ≥ 1.6 (must be extracted in a CLIA or equivalent certified lab)</p> <p>-Fibroblast cells</p>	<p><input type="checkbox"/> Peripheral Blood (EDTA); # Tubes: _____</p> <p><input type="checkbox"/> Extracted DNA; Source: _____</p> <p><input type="checkbox"/> Saliva (kit must be provided by MGL)</p> <p><input type="checkbox"/> Other, please describe: _____</p> <p>Please note: failure to provide a date of collection can delay release of results</p> <p>Sample Collected Date (required): _____</p>





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Name: (First)

(MI)

(Last)

DOB: (MM/DD/YY)

Tumor/Biopsy-based Comprehensive Testing

Please check here if blood or DNA is provided for confirmation testing. Blood Collected: (MM/DD/YY)

NF1/SPRED1 on biopsied CALs and Neurofibromas

Please contact the laboratory at least one week in advance of the biopsy before ordering this test as media must be provided in advance and special shipping instructions apply. Biopsies must arrive within 60 hours of collection

NF14C: Sanger (RNA) and Del/Dup: NF1 (with automatic reflex to *SPRED1*) on biopsied CALs

NF14N: Sanger (RNA) and Del/Dup: NF1 on biopsied neurofibromas

NF2/Schwannomatosis

NF2-NG: Fresh/Frozen Tumor for NGS and Del/Dup: NF2 only

NF24: Tumor Block for Sanger and Del/Dup: NF2 only

SCH-NG: Fresh/Frozen Tumor for NGS and Del/Dup: LZTR1, NF2, and SMARCB1

SCHP: Tumor Block for Sanger and Del/Dup: NF2, LZTR1, and SMARCB1

Rhabdoid Tumor Predisposition Syndrome

RT-NG: Fresh/Frozen Tumor for NGS SMARCB1 and SMARCA4; and Del/Dup: SMARCB1 only

SB14RT: Tumor Block for Sanger and Del/Dup: SMARCB1 only

RASopathy Related Conditions

Meningiomatosis

NNP-NG: Fresh/Frozen Tumor for NGS (no NF1): BRAF, CBL, HRAS, KRAS, LZTR1, MAP2K1, MAP2K2, NRAS, PPP1CB, PTPN11, RAF1, RASA2, RIT1, SHOC2, SOS1, SOS2, and SPRED1; and Del/Dup: SPRED1 and LZTR1

RAS-NG: Fresh/Frozen Tumor for NGS: BRAF, CBL, HRAS, KRAS, LZTR1, MAP2K1, MAP2K2, NF1, NRAS, PPP1CB, PTPN11, RAF1, RASA2, RIT1, SHOC2, SOS1, SOS2, and SPRED1; and Del/Dup: NF1, SPRED1, and LZTR1

MEN-NG: Fresh/Frozen Tumor for NGS: NF2, SMARCB1, SMARCE1, and SUFU; and Del/Dup: NF2 and SMARCB1

Peripheral Nerve Sheath Tumor Testing

PNT-NG: Fresh/Frozen Tumor for NGS: NF1, NF2, KRAS, LZTR1, PTPN11 and SMARCB1; and Del/Dup: NF1, NF2, LZTR1, and SMARCB1

Tuberous Sclerosis Complex

TSC-NG: Fresh/Frozen Tumor for NGS and Del/Dup: TSC1 and TSC2

Additional Information

Test Description Key:

Next Generation Sequencing (NGS)

Sanger Sequencing (Sanger)

Deletion/Duplication analysis (Del/Dup)

Please contact the lab via phone (205) 934-5562 or via email at medgenomics@uabmc.edu if you have any questions when completing this form.

For additional information, visit our website at www.uab.edu/medicine/genetics/medical-genomics-laboratory

Important points of consideration for testing

- The MGL offers next generation sequencing testing options that provide the ability to identify variants (indels and substitutions) as low as 3% of the alleles, depending on coverage in the regions of interest.
- NF1/SPRED1 biopsy-based testing is considered the “gold standard” approach for confirming a diagnosis of mosaic/segmental NF1 or Legius Syndrome.
- A minimum of two biopsies is required for NF1 testing. Two or more tumors are suggested for our other testing options. There are no additional fees associated with testing on additional biopsy specimens.
- When proceeding with tumor-based testing for NF2, test code “SCH-NG” or “SCHP” (*NF2, SMARCB1, and LZTR1*) is suggested unless the patient has additional findings unique to NF2.

Specimen Requirements

Accepted Specimens

Specimen requirements vary based on test requested; please see our website for more details.

CALs or Neurofibromas: require special media transport (kits are provided upon request, to be arranged at least one week in advance of procedure)

Fresh/Frozen Tumors: please submit a pathology report; for additional requirements, see tumor submission checklist

Formalin-Fixed Paraffin-Embedded Tumors (Tumor Block): please submit a pathology report; blocks are preferred to curls, when available; for additional requirements, see tumor submission checklist

Specimen Information:

Frozen Fresh

Paraffin Curls Paraffin Block

Extracted DNA; Source: _____

Biopsy-CAL-spot; # biopsies: _____

Biopsy-Neurofibroma; # biopsies: _____

Please note: failure to provide a date of collection can delay release of results

Tumor Collection Date (required): _____



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Name: (First)

(MI)

(Last)

DOB: (MM/DD/YY)

Sanger Testing from Blood/Saliva/DNA
NF1/Legius syndrome and Other RASopathy Related Conditions

NF1-R: Sanger and Del/Dup: NF1 (RNA)

NFSP-R: Sanger and Del/Dup: NF1 (RNA) and SPRED1 (gDNA)

Von Hippel-Lindau

VHL1: Sanger and Del/Dup: VHL

PTEN-Related Disorders

PTEN1: Sanger and Del/Dup: PTEN

Fragile X syndrome

FRX: PCR and, if needed, reflexive confirmatory testing by Southern blot analysis: FMR1

Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)

MCD1: Targeted analysis of exon 11 and, if needed, reflexive full gene sequencing by Sanger: ACADM

Autosomal Recessive Polycystic Kidney Disease

PKDL: Linkage Analysis for informativity

PKDPL: Prenatal Linkage (see Prenatal Specimen Requirements)

FATHER: Name and DOB (mm/dd/yyyy)

MOTHER: Name and DOB (mm/dd/yyyy)

Known Variant Testing

KT2: Targeted detection of a specific, previously identified known variant in any gene that is available at our lab by Sanger sequence, MLPA, and/or FISH analysis (**Complete Previous Testing History: Page 1**)

KT2-NG: Targeted testing for a known variant with deep coverage of the alleles and detection of mosaicism for a variant present in at least 3% of alleles (**Complete Previous Testing History: Page 1**)

RT2: Targeted RNA-based testing for VOUS found during Next Generation Sequencing (**Complete Previous Testing History: Page 1**)

PT2: Prenatal testing (see Prenatal Specimen Requirements; **Complete Previous Testing History: Page 1**)

MCC: Blood specimen for mother provided for maternal cell contamination studies (required if not previously tested)

 Other (unlisted options, please indicate below)

Please contact lab before selecting this option

Additional Information
Test Description Key:

Next Generation Sequencing (**NG**)

Sanger Sequencing (**Sanger**)

Deletion/Duplication analysis (**Del/Dup**)

Please contact the lab via phone (205) 934-5562 or via email at medgenomics@uabmc.edu if you have any questions when completing this form.

For additional information, visit our website at www.uab.edu/medicine/genetics/medical-genomics-laboratory

Specimen Requirements
Accepted Prenatal Specimens

Specimen requirements vary based on test requested; please see our website for more details.

Direct CVS: minimum 10 mg cleaned villi

Direct amniotic fluid: minimum 10 ml fluid

Cultured CVS: Two T25 flasks (>70% confluent)

Cultured amniocytes: Two T25 flasks (>70% confluent)

Prenatal Specimen Information:

Amniotic Fluid Direct CVS (cleaned)

Cultured Amniocytes Cultured Villus Cells

Location of back-up culture (required): _____

Sample Collected Date (required): _____

Accepted Specimens

Specimen requirements vary based on test requested; please see our website for more details.

Blood: 3-6ml EDTA (must arrive within **60-72 hours of collection** for RNA-based tests)

DNA: extracted from lymphocyte cells, a minimum of 25ul at 3 μ g, O.D. value at 260:280nm \geq 1.6 (must be extracted in a CLIA or equivalent certified lab)

Sperm (for KT2-NG only): Fresh, sterile semen collection using a local sperm bank/cryobank facility

Specimen Information:

Peripheral Blood (EDTA); # Tubes: _____

Extracted DNA; Source: _____

Other, please describe: _____

Please note: failure to provide a date of collection can delay release of results

Sample Collected Date (required): _____



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Name: (First)	(MI)	(Last)	DOB: (MM/DD/YY)
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Billing

Please hold sample until further notice from the ordering facility.

Important Information

By completing this form, you **agree** that you have discussed the MGL's billing policies with your patient.

Credit card information **MUST** be provided with sample submission for self-pay clients. **Please note:** If you are paying via self-payment or requesting a benefits investigation, there will be a **3-5 working day delay** on the initiation of your test. Requests for **cancellation** of ongoing testing must be submitted to the laboratory **within three working days of specimen arrival**. Individuals or institutions submitting requests after the three working day window may still incur charges for the cost of testing.

Full information on the billing policies is available at www.uab.edu/medicine/genetics/medical-genomics-laboratory

Institutional Bill

Please check box if billing institution should receive report directly

Institution:	PO# (if applicable):
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Address:

City:	State:	Zip:
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Contact (Name and Title):	Preferred method of contact: <input type="checkbox"/> Email <input type="checkbox"/> Phone
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Email:	Phone:	Fax:
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Self-Payment Enclosed

Visa MasterCard Discover American Express

Name as it appears on card:

Card Number:	Expiration: (MM/YY)	3-digit Security Code:
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Cardholder's Signature:	Preferred method of contact: <input type="checkbox"/> Email <input type="checkbox"/> Phone
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Email:	Phone:
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Bill Third Party Insurance Company

Please include a copy of the pre-approval statement or provide the approval number if payment has been pre-authorized in advance of shipment.

Insurance pre-verification/authorization previously performed? Yes No If yes, approval number is required:

Please check box if you would **not** like insurance pre-verification/authorization to be performed by the MGL.

Please send a **legible copy** of the patient's insurance card, front and back.

ICD-10 Codes (**required**):

Important Considerations for Insurance Billing

For a list of contracted insurance companies, please visit our website or call our billing coordinator at 205-934-5523. As insurance prices are not listed, please call the billing coordinator to request a quote, if needed.

The MGL will contact the insurance provider to inquire regarding the CPT code coverage for all samples submitted for insurance payment. The healthcare provider will be contacted with the copay/deductible and also in cases where the insurance provider denies coverage of the requested codes or supporting documents are required from the provider to confirm coverage. **This service is not offered for prenatal samples.**

Please note: An insurance verification is not a guarantee of payment. Out of State Medicaid is not accepted under any circumstances. All RUSH fees must be paid up front. By completing this form, you agree that you have discussed the MGL's billing policies with your patient.



Informed Consent for Genetic Testing

This form does not need to be returned to the Medical Genomics Laboratory if Informed Consent portion of the Test Request form has been signed.*

I hereby consent for:

Name:	DOB:	Gender:
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To participate in genetic testing for the following RNA/DNA-based cascade of tests ordered by my physician at the University of Alabama at Birmingham (UAB) Medical Genomics Laboratory (MGL):

Genetic Tests:

I understand that:

1. Any biological samples submitted for genetic testing (e.g., blood, cheek cells, saliva, amniotic fluid, chorionic villi, tumor, and/or tissue) will be removed from me and/or my minor child(ren) using standard techniques which carry their associated risks.
2. Any samples obtained will be used for the purpose of attempting to determine if I and/or members of my family carry genetic changes in the disease genes ordered by my physician.
3. The genetic tests performed at the MGL are the most sensitive developed and are highly specific. However, sensitivity and specificity are test-dependent. Additional testing details and the specific detection rates of each test can be found at www.genetics.uab.edu/medgenomics.

4. The following are possible outcomes for the specific tests listed above:

Positive	Unknown Significance	Negative
This is an indication that I may be predisposed to or have the specific disease, or condition tested. Further testing may be needed to confirm the diagnosis.	There may be a possibility that the laboratory findings will be ambiguous or of unknown significance. This may require additional testing from me or my family members. In rare circumstances, findings may be suggestive of a condition different than the diagnosis that was originally made.	There is a chance that I will still have this genetic condition even though the genetic test results are negative. Due to limitations in technology and incomplete knowledge of genes, some changes in RNA/DNA or protein products that cause disease may not be detected by this test.

5. In other cases, the RNA/DNA test is unable to identify an abnormality although the abnormality may still exist. This event may be due to incomplete knowledge of the gene structure or an inability of current technology to identify certain types of mutations in the gene. When clinically necessary, the MGL may use a method called linkage analysis. This method is not a direct test, but will report the probability that you and/or family members have an inherited disease or disorder. In some families, the markers used in linkage analysis may be uninformative. If so, linkage testing cannot provide results for the family members in question.

6. The RNA/DNA analysis performed by the MGL is specific for the genetic test listed above and in no way guarantees my health or the health of my living or unborn children. The MGL cannot be responsible for an erroneous clinic diagnosis made elsewhere.

7. The tests performed at the MGL are expanded and improved continuously. The tests offered are not considered research but are considered the best and newest laboratory service that can be offered. Genetic testing is complex and utilizes specialized materials so there is always some very small possibility that the test will not work properly or that an error will occur. There is a low error rate (perhaps 1 in 1000 samples) even in the best laboratories. Additionally, in very rare instances, this test may reveal an important genetic change that is not directly related to the clinical reason for ordering this test. This would be considered an incidental finding. The MGL reserves the right to report these incidental findings if they are clinically relevant to the patients and/or their families. In such instances, these results will be discussed with my healthcare provider and additional testing may be recommended. My signature acknowledges my voluntary participation in this test, but in no way releases the laboratory and staff from the MGL from their professional or ethical responsibility to me.

8. The MGL does not return DNA samples to individuals or physicians. While the MGL is not a specimen banking facility, in some cases it may be possible for the laboratory to reanalyze my remaining DNA upon request. The request for additional studies must be ordered by my referring physician/counselor and there will be an additional fee.



9. An aliquot of my DNA/RNA may be used for validation, educational and/or research purposes. For some molecular genetic tests, a synopsis of clinical information and test results may be included in HIPAA-compliant, de-identified public databases as part of the National Institute of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms. If I would like to opt out of participation, I can contact the MGL via email at medgenomics@uab.edu or calling the laboratory at 205-934-5562.

10. Because of the complexity of genetic testing and the important implications of the test results, results will only be reported to me through a physician, genetic counselor, or a certified genetics professional. The results are confidential to the extent allowed by law. They will only be released to other medical professionals or other parties with my written consent or as otherwise allowed by law. Participation in testing is completely voluntary.

11. **For Prenatal Testing:** If prenatal diagnosis is being performed, fetal cells obtained by chorionic villus sampling or amniocentesis will be used. In order to perform accurate prenatal diagnosis, biological samples are required for the fetus as well as from the affected individual in the family and from the biological mother.

12. I and/or my physician/counselor have signed the informed consent portion of the test order form indicating that we have discussed the items on this document and I will also receive a copy of this consent form.

Subject's Signature _____ Date _____

Physician's Signature _____ Date _____

Please Print Subject's Name _____

Please Print Physician's Name _____

Assent of Parent _____ Date _____

Genetic Counselor's Signature _____ Date _____

Assent of Child _____ Date _____

Please Print Genetic Counselor's Name _____





Patient ID:

Referring Physician: _____ Date of Exam ____/____/____

DEMOGRAPHIC INFORMATIONGender: Male Female

Date of Birth: ____/____/____

Ethnicity: Mother: White Black Native American Hispanic Asian Other:
Father: White Black Native American Hispanic Asian Other:**DIAGNOSIS**

Clinical diagnosis: NF1 Spinal NF NF Noonan Segmental NF1 Noonan syndrome Noonan syndrome with multiple lentigines (LEOPARD) syndrome Cardio-facio-cutaneous syndrome (CFC) Costello syndrome Multiple CAL spots-only Familial multiple CAL spots-only Legius syndrome Isolated neurofibromas Single NF1 feature Unknown

NF1 NIH criteria:

>6 CAL spots >5mm, postpubertal >15mm Optic glioma
 >2 neurofibromas or 1 plexiform NF >2 Lisch nodules
 Axillary or inguinal freckling A distinct osseous lesion
 First degree relative diagnosed with NF1 by above criteria
 Does patient fulfill NIH diagnostic criteria for NF1? Yes No

Family history: Sporadic (proband is a "founder") Familial (proband is a "non-founder") UnknownConsanguinity: Yes No Unknown**GENERAL INFORMATION**Height: ____ cm (Short stature)Head circumference: ____ cm (Macrocephaly)

Weight: ____ kg

Clinical Features

Craniofacial: Absent Unknown
 Macrocephaly Bitemporal narrowing Hypertelorism
 Palpebral ptosis Low posterior hairline Low set / rotated ears
 Midface hypoplasia Short / webbed neck Downslanting palpebral fissures
 Other: _____

Ectodermal: Please provide detail on size/ location of the CAL-spots and other hyper/hypopigmentation areas on figure page 3

Absent Unknown
 Deep palmar/plantar creases Dry/hyperkeratotic skin Hair abnormalities
 Multiple nevi / lentigines Abnormal/sparse eyebrows Other _____

Café-au-lait spots: 0 1-5 ≥6 to 100 >100

General impression on the borders of the CAL-spots:

typical well-defined smooth borders diameter:
 irregular margins, ragged borders diameter:

Skin fold freckling: None Unknown

Comments (e.g. very faint, etc): _____

Groin Left Right _____Axilla Left Right _____Submammary Left Right _____



Lisch nodules: None Unknown Left Right

Neurofibromas:

Cutaneous neurofibromas (soft nodules that project above the skin):

Histopathologically confirmed: Y / N

0 1 2-6 6-99 100-500 >500

Intradermal neurofibromas (soft depression within the skin w/ pinkish overlying discoloration):

Histopathologically confirmed: Y / N

0 1 2-6 6-99 100-500 >500

Subdermal neurofibromas (firm nodules palpable underneath the skin):

Histopathologically confirmed: Y / N

0 1 2-6 6-99 100-500 >500

Plexiform neurofibromas:

Histopathologically confirmed: Y / N

<input type="checkbox"/> None	<input type="checkbox"/> Visible from outside	<input type="checkbox"/> Internal
	<input type="checkbox"/> With hyperpigmentation	<input type="checkbox"/> Without hyperpigmentation

<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Trunk	<input type="checkbox"/> L Arm	<input type="checkbox"/> L Hand	<input type="checkbox"/> L Leg	<input type="checkbox"/> L Foot
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Genital area	<input type="checkbox"/> R Arm	<input type="checkbox"/> R Hand	<input type="checkbox"/> R Leg	<input type="checkbox"/> R Foot

Spinal neurofibromas (arising from the spinal dorsal nerve root): If present, please provide detail on figure page 3

Histopathologically confirmed: Y / N

<input type="checkbox"/> Unknown	<input type="checkbox"/> Absent by MRI	<input type="checkbox"/> Present, asymptomatic	<input type="checkbox"/> Present, symptomatic
<input type="checkbox"/> unilateral	<input type="checkbox"/> bilateral;		

C_____ T_____ L_____ S_____ regions.

Other neoplasms: Absent Unknown

Optic glioma:

<input type="checkbox"/> Absent by MRI	<input type="checkbox"/> Present by MRI, symptomatic	<input type="checkbox"/> Present by MRI, asymptomatic
	<input type="checkbox"/> Nerve (L and/or R)	<input type="checkbox"/> Chiasm

<input type="checkbox"/> Hypothalamic glioma	<input type="checkbox"/> Brainstem glioma	<input type="checkbox"/> Other glioma
<input type="checkbox"/> MPNST	<input type="checkbox"/> JMM	<input type="checkbox"/> Rhabdomyosarcoma
<input type="checkbox"/> Pheochromocytoma	<input type="checkbox"/> Colonic polyps	<input type="checkbox"/> Lipoma
<input type="checkbox"/> schwannoma	<input type="checkbox"/> meningioma	<input type="checkbox"/> juvenile xanthogranuloma
<input type="checkbox"/> breast cancer	<input type="checkbox"/> Other, specify: _____	

Skeletal: Absent Unknown
 Long bone dysplasia Pseudarthrosis Sphenoid wing dysplasia
 Bone cysts scoliosis Dysplastic vertebrae
 pectus excavatum pectus carinatum Cubitus valgus
 Broad chest / telethelia Other: _____

Cardiovascular: Absent Unknown
 Present: Hypertension Aortic stenosis Renal artery stenosis
 Moya moya Pulmonary valve stenosis
 Arrhythmia Hypertrophic cardiomyopathy
 Atrial septal defect Ventricular septal defect
 ECG anomalies Mitral valve anomaly
 Unknown Other _____

Development: Normal for age Delayed for age Hypotonic Hypertonic
 Gross Motor Delays Fine Motor Delays ADD Speech Delays
 Hyperactivity Learning disability Unknown Exam not done
 Other: _____ IQ: **Full scale** _____, **Verbal** _____, **Performance** _____.



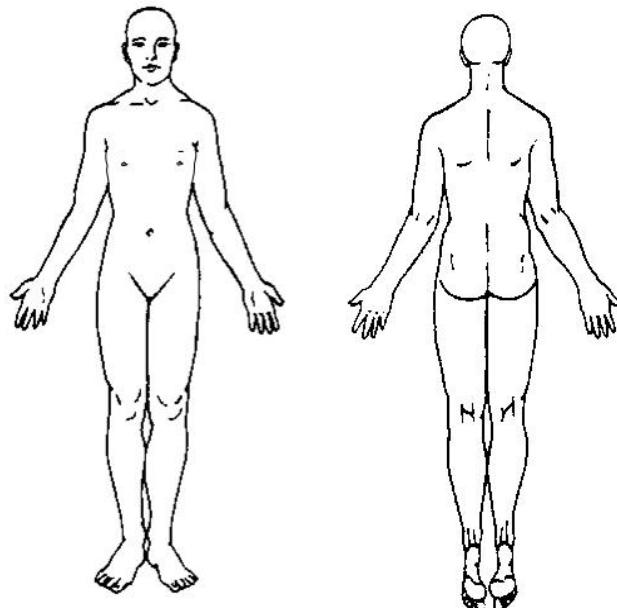


Education: Too young for school At or above age level Below age level Unknown
 HS completion College graduate Higher degree

Hematological: abnormal hemostasis Factor XI deficiency Other: _____ Unknown

Segmental NF phenotype: Absent Possible

Please indicate location/size of pigmentary lesions and/or neurofibromas



Indicate size and location of

Neurofibromas



CAL-spots



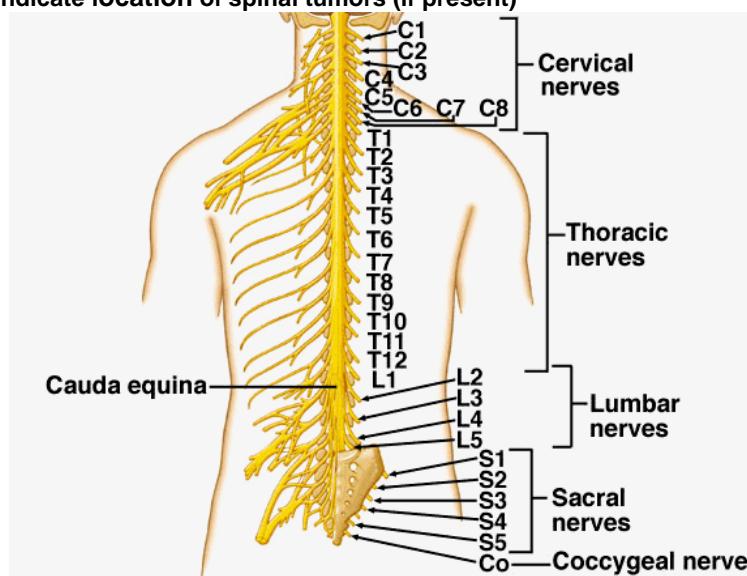
Freckling



Hyperpigmented region



Please indicate location of spinal tumors (if present)



Additional comments/remarks:

