

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)

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

Additional Information

<p>Test Description Key: Next Generation Sequencing (NGS) Deletion/Duplication analysis (Del/Dup)</p>	<p>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</p>
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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 ≥350X and 99.9% ≥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 ≥200X. Remaining regions are covered at ≥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

<p>Accepted Specimens</p> <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) -Saliva: OGR-575 DNA Genotek (kits are provided upon request) -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) -Fibroblast cells</p>	<p>Specimen Information:</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

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

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

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

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*

Meningiomatosis

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 Information:

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

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): _____



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

Sanger Testing from Blood/Saliva/DNA

NF1/Legius syndrome and Other RASopathy Related Conditions <input type="checkbox"/> NF1-R: Sanger and Del/Dup: <i>NF1 (RNA)</i> <input type="checkbox"/> NFSP-R: Sanger and Del/Dup: <i>NF1 (RNA)</i> and <i>SPRED1 (gDNA)</i>	Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD) <input type="checkbox"/> MCD1: Targeted analysis of exon 11 and, if needed, reflexive full gene sequencing by Sanger: <i>ACADM</i>
Von Hippel-Lindau <input type="checkbox"/> VHL1: Sanger and Del/Dup: <i>VHL</i>	Autosomal Recessive Polycystic Kidney Disease <input type="checkbox"/> PKDL: Linkage Analysis for informativity
PTEN-Related Disorders <input type="checkbox"/> PTEN1: Sanger and Del/Dup: <i>PTEN</i>	<input type="checkbox"/> PKDPL: Prenatal Linkage (see Prenatal Specimen Requirements)
Fragile X syndrome <input type="checkbox"/> FRX: PCR and, if needed, reflexive confirmatory testing by Southern blot analysis: <i>FMR1</i>	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
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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: <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Direct CVS (cleaned) <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> 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 3µg, O.D. value at 260:280nm ≥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: <input type="checkbox"/> Peripheral Blood (EDTA); # Tubes: _____ <input type="checkbox"/> Extracted DNA; Source: _____ <input type="checkbox"/> Other, please describe: _____ Please note: failure to provide a date of collection can delay release of results Sample Collected Date (required): _____



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.



MEDICAL GENOMICS LABORATORY: NF1/SPRED1 & RASOPATHIES PHENOTYPIC CHECKLIST FORM



Patient ID: _____

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

DEMOGRAPHIC INFORMATION

Gender: 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 Multiple CAL spots-only
 Spinal NF Familial multiple CAL spots-only
 NF Noonan Legius syndrome
 Segmental NF1 Isolated neurofibromas
 Noonan syndrome Single NF1 feature
 Noonan syndrome with multiple lentiginos (LEOPARD) syndrome
 Cardio-facio-cutaneous syndrome (CFC)
 Costello syndrome 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") Unknown
Consanguinity: Yes No Unknown

GENERAL INFORMATION

Height: ___ cm (Short stature) Head circumference: ___ cm (Macrocephaly) Weight: ___ kg

Clinical Features

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

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

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

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Submammary	<input type="checkbox"/>	<input type="checkbox"/>	_____



MEDICAL GENOMICS LABORATORY: NF1/SPRED1 & RASOPATHIES PHENOTYPIC CHECKLIST FORM



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

None Visible from outside Internal
 With hyperpigmentation Without hyperpigmentation

Head Neck Trunk L Arm L Hand L Leg L Foot
 Abdomen Pelvis Genital area R Arm R Hand R Leg R Foot

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

Histopathologically confirmed: Y / N

Unknown Absent by MRI Present, asymptomatic Present, symptomatic

unilateral bilateral;

C_____ T_____, L_____, S_____ regions.

Other neoplasms: Absent Unknown

Optic glioma:

Absent by MRI Present by MRI, **symptomatic** Present by MRI, **asymptomatic**
 Nerve (L and/or R) Chiasm

Hypothalamic glioma Brainstem glioma Other glioma
 MPNST JMML Rhabdomyosarcoma
 Pheochromocytoma Colonic polyps Lipoma
 schwannoma meningioma juvenile xanthogranuloma
 breast cancer Other, specify:_____

Skeletal:

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

Cardiovascular:

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



MEDICAL GENOMICS LABORATORY: NF1/SPRED1 & RASOPATHIES PHENOTYPIC CHECKLIST FORM

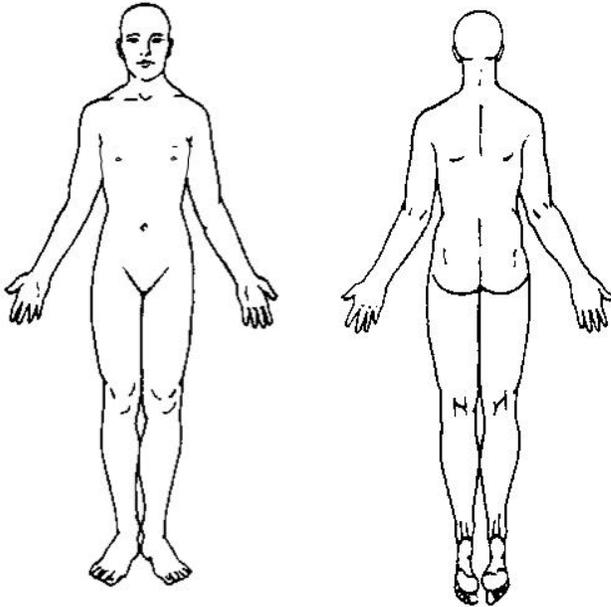


Education: Too young for school At or above age level Below age level Unknown
 HS completion College graduate Higher degree

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

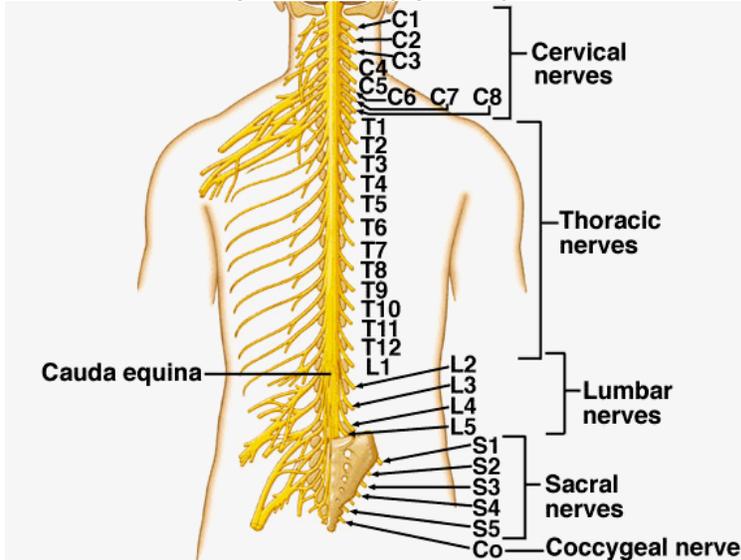
Neurofibromas 

CAL-spots 

Freckling 

Hyperpigmented region 

Please indicate location of spinal tumors (if present)



Additional comments/remarks:



MEDICAL GENOMICS LABORATORY: NF2 & SCHWANNOMATOSIS PHENOTYPIC CHECKLIST FORM



Patient ID: _____

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

DEMOGRAPHIC INFORMATION

Gender: Male Female Date of Birth: ___/___/___

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

DIAGNOSIS

Does the patient have a clinical diagnosis of NF2? Yes No If Yes, age at diagnosis: _____

Family history: Sporadic Familial Unknown

SIGNS AND SYMPTOMS

Ear: Absent Unknown Present: Bilateral Deafness Unilateral Deafness Age of symptoms: _____
 Balance Dysfunction Tinnitus
 Audiometric Abnormality, please describe: _____
 Other, please describe: _____

Eyes Absent Unknown Present: Blindness Age of Symptoms: _____
 Lenticular opacities
 Lisch nodules
 Left Right
 Bilateral Unknown

Schwannomas

Vestibular schwannomas Age of Symptoms: _____
 Bilateral
 Unilateral
 No evidence of vestibular nerve tumor by MRI (Age: ___ yrs)
 Lack of symptoms of vestibular nerve tumor, but no MRI done (Age: ___ yrs)
 Unknown

Spinal schwannomas Age of Symptoms: _____
 Present
 No evidence by MRI (Age: ___ yrs)
 Lack of symptoms, but no MRI done (Age: ___ yrs)
 Unknown
Provide location of spinal tumors: C ___ to C ___, T ___ to T ___, L ___ to L ___

Other schwannomas Age of Symptoms: _____
 Absent Unknown
 Head Neck Trunk L Arm L Hand L Leg L Foot
 Abdomen Pelvis Genital area R Arm R Hand R Leg R Foot

Present only in an anatomically limited distribution(single limb or segment of the spine): yes or no

Result *SMARCB1*-staining on the tumor specimen: Abnormal (no *SMARCB1*-staining)
 Normal (*SMARCB1* staining)
 Not performed



MEDICAL GENOMICS LABORATORY: NF2 & SCHWANNOMATOSIS PHENOTYPIC CHECKLIST FORM



Meningiomas

- Present, Location: _____
- No evidence by MRI (Age: ___yrs)
- Unknown

Age of Symptoms: _____

Other spinal tumors

- Absent by MRI
 - Present, asymptomatic
 - Present, symptomatic
 - Unknown
- Pathology Known: Yes, please specify: _____ No

Age of Symptoms: _____

Provide location of spinal tumors: C ___ to C ___, T ___ to T ___, L ___ to L ___

Cranial nerve involvement

- Present, Location: _____
- No evidence by MRI (Age: ___yrs)
- Unknown

Age of Symptoms: _____

Skin

CAL spots

- 1
- 2-3
- 4-5
- >5-10
- >10

Age of Symptoms: _____

Neurofibromas

- 1-5
- ≥6-99
- ≥100

Age of Symptoms: _____

Skin fold freckling

- | | Left | Right |
|------------|--------------------------|--------------------------|
| Groin | <input type="checkbox"/> | <input type="checkbox"/> |
| Axilla | <input type="checkbox"/> | <input type="checkbox"/> |
| Submammary | <input type="checkbox"/> | <input type="checkbox"/> |

Age of Symptoms: _____

Please indicate location of spinal tumors (if present)

Additional comments/remarks:

