ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform genetic testing for vascular malformation syndrome.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR VASCULAR MALFORMATION SYNDROME TESTING

Patient Name _____ Date of Birth_____ /_____/_____Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

Genetic Counselor _____ Counselor Phone (_____)_____

Patient's Ethnicity (check all that apply)

[ ] African American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

Patient's Clinical Diagnosis [ ] Confirmed [ ] Suspected [ ] Unknown

[ ] Hereditary hemorrhagic telangiectasia (HHT)
[ ] HHT/juvenile polyposis
[ ] Capillary malformation/arteriovenous malformation (CM-AVM)
[ ] Parkes Weber
[ ] Multiple cutaneous and mucosal venous malformations (VMCM)
[ ] Other _____
[ ] Glomuvenous malformation (GM)
[ ] Cerebral cavernous malformation (CCM)
[ ] PTEN hamartoma tumor syndrome (PHTS)
[ ] Proteus syndrome (PS)/Proteus-like syndrome
[ ] Pulmonary arterial hypertension (PAH)

Patient's Manifestations/Symptoms (check all that apply and describe)

[ ] Telangiectasia (location(s): _____
[ ] Capillary malformations (location(s): _____
[ ] AVM(s) (location(s): _____
[ ] Cerebral cavernous malformation(s) (number): _____
[ ] Venous malformation(s) (locations(s): _____
[ ] Musculoskeletal/neurological: _____
[ ] Other_____

Is there any relevant FAMILY HISTORY? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the relative's RELATIONSHIP to the patient. List their symptoms and age of onset.
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
Please attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for a vascular malformation syndrome? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the genes, disorder, methodology, and results_____

Circle the test you intend to order:

2007384 Vascular Malformations Panel, Sequencing and Deletion/Duplication, 14 Genes. Genes include *ACVRL1, BMP9, BMPR2, CAV1, CCM1, CCM2, CCM3, ENG, GLMN, KCNK3, PTEN, RASA1, SMAD4, TEK*.

2001961 Familial Mutation, Targeted Sequencing: targeted testing for a known familial sequence variant. A copy of the relative's lab report is REQUIRED. Contact an ARUP genetic counselor prior to ordering.

For questions, contact an ARUP genetic counselor at (800) 242-2787, ext. 2141

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