ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR VASCULAR MALFORMATIONS SYNDROME TESTING

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American

☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Patient's diagnosis: ☐ Confirmed ☐ Suspected ☐ Unknown

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

Does the patient have symptoms/manifestations? ☐ No ☐ Yes (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: _____
☐ Lymphedema: _____
☐ Other symptom(s): _____

Has the patient undergone previous DNA testing for this condition? ☐ No ☐ Yes ☐ Unknown

If yes, describe the gene(s), disorder(s), methodology, and results: _____

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 the family member(s)? ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing.)

Check the test you intend to order.

☐ **2007384 Vascular Malformations Panel, Sequencing and Deletion/Duplication:** Preferred DNA test to confirm clinical diagnosis of a genetic-related vascular malformation disorder.

☐ **2001961 Familial Mutation, Targeted Sequencing** Tests for a sequence variant previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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