

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

**PATIENT HISTORY FOR HEREDITARY HEMORRHAGIC TELANGIECTASIA (HHT) 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 \_\_\_\_\_

**Does the patient have SYMPTOMS?**     No     Yes; please check all that apply  
 Nosebleeds (frequency): \_\_\_\_\_     Telangiectasia (locations): \_\_\_\_\_  
 Capillary malformation:  Multiple  Solitary    Location: \_\_\_\_\_  
 Brain AVM     Liver AVM     Lung AVM     Spinal AVM  
 Juvenile polyps     Pulmonary hypertension     Stroke (age): \_\_\_\_\_     Other: \_\_\_\_\_

**Does the patient have a FAMILY HISTORY of HHT?**     No     Yes     Unknown  
**If yes, attach a PEDIGREE or specify the family members' RELATIONSHIP to the patient. List their symptoms:**

\_\_\_\_\_

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

**Has the patient undergone previous DNA testing for HHT?**     No     Yes     Unknown  
 If yes, please describe test(s) and results: \_\_\_\_\_

**Circle the test you intend to order**

<b>Order for symptomatic individuals who meet clinical criteria for HHT</b>	
0051382	HHT ( <i>ACVRL1</i> and <i>ENG</i> ) Sequencing and Deletion/Duplication <ul style="list-style-type: none"> <li>• Clinical sensitivity 85% for HHT</li> </ul>
2009008	HHT ( <i>ACVRL1</i> and <i>ENG</i> ) Sequencing and Deletion/Duplication with Reflex to <i>SMAD4</i> Sequencing and Deletion/Duplication <ul style="list-style-type: none"> <li>• Clinical sensitivity 87% for HHT</li> </ul>
<b>Order for symptomatic individuals who do not meet clinical criteria for HHT</b>	
2009337	HHT Panel, Sequencing and Deletion/Duplication, 5 Genes ( <i>ACVRL1</i> , <i>BMP9</i> , <i>ENG</i> , <i>RASA1</i> and <i>SMAD4</i> ) <ul style="list-style-type: none"> <li>• Components of this panel are available individually (see aruplab.com)</li> </ul>
<b>Order when an HHT gene mutation has previously been identified in a family member</b>	
2001961	Familial Mutation, Targeted Sequencing
0051348	HHT ( <i>ACVRL1</i> and <i>ENG</i> ) Deletion/Duplication

Other: \_\_\_\_\_

Master Label

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