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 HEREDITARY HEMORRHAGIC TELANGIECTASIA (HHT) 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: _____

Does the patient have symptoms? ☐ No ☐ Yes (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 symptom(s): _____

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

If yes, describe the test(s) and results: _____

_____

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the affected 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.

Order for symptomatic individuals who meet clinical criteria for HHT

☐ **0051382 HHT (*ACVRL1* and *ENG*) Sequencing and Deletion/Duplication:** Clinical sensitivity 85% for HHT

☐ **2009008 HHT (*ACVRL1* and *ENG*) Sequencing and Deletion/Duplication with Reflex to *SMAD4* Sequencing and Deletion/Duplication:** Clinical sensitivity 87% for HHT

Order for symptomatic individuals who do not meet clinical criteria for HHT

☐ **2009337 Hereditary Hemorrhagic Telangiectasia (HHT) Panel, Sequencing and Deletion/Duplication** Components of this panel are available individually (see aruplab.com)

Order when an HHT gene mutation has previously been identified in a family member

☐ **2001961 Familial Mutation, Targeted Sequencing**

☐ **0051348 HHT (*ACVRL1* and *ENG*) Deletion/Duplication**

Master Label

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