ARUP LABORATORIES

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

## PATIENT HISTORY FOR HEMOPHILIA A or B GENE 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 [ ] American Indian
[ ] Caucasian [ ] Hispanic [ ] Middle Eastern [ ] Other_____

**CLINICAL FINDINGS of HEMOPHILIA** (check all that apply)

[ ] None
[ ] Spontaneous bleeding (location(s):_____frequency:_____)
[ ] Excessive bruising [ ] Hemarthrosis [ ] Chronic joint disease
[ ] Intracranial hemorrhage [ ] GI bleeding/hemorrhage [ ] Menorrhagia
[ ] Prolonged bleeding post trauma/surgery [ ] Other _____

**INDICATE THE DISEASE SEVERITY IN THIS PATIENT**

[ ] N/A [ ] Mild [ ] Moderate [ ] Severe [ ] Unknown

**LABORATORY FINDINGS**

Factor VIII activity [ ] Abnormal_____% [ ] Normal [ ] Not performed
vonWillibrands factor activity [ ] Abnormal_____% [ ] Normal [ ] Not performed
Factor IX activity [ ] Abnormal_____% [ ] Normal [ ] Not performed
Other laboratory results _____

**FAMILY HISTORY OF HEMOPHILIA?** [ ] No [ ] Yes [ ] Unknown

**If yes**, what is the **RELATIONSHIP** of family member(s) to the patient? _____
Is the relative? [ ] a healthy carrier [ ] affected
List the **GENE and MUTATION(S)** identified in the relative(s) or include a copy of the laboratory result:
_____

**INDICATE THE DISEASE SEVERITY IN AFFECTED MALES IN THE FAMILY**

[ ] N/A [ ] Mild [ ] Moderate [ ] Severe [ ] Unknown

**HAS THE PATIENT UNDERGONE PREVIOUS DNA TESTING FOR HEMOPHILIA?**

[ ] Yes [ ] No [ ] Unknown **If yes**, please specify test(s) and result: _____

## Circle the test you intend to order OR write the test name and number below:

| |
|---|
| **Recommended genetic testing for Hemophilia A (*F8*):** |
| **2001614 Hemophilia A (*F8*) 2 Inversion with Reflex to Sequencing and Reflex to Deletion/Duplication**<br>Components available separately: **Hemophilia A (*F8*) 2 Inversions (2001759)** and **Hemophilia A (*F8*) Sequencing (2001747)** and **Hemophilia A (*F8*) Deletion/Duplication (2001751)** |
| **Recommended genetic testing for Hemophilia B (*F9*)** |
| **2010494 Hemophilia B (*F9*) Sequencing and Deletion/Duplication**<br>Components available separately: **Hemophilia B (*F9*) Sequencing (2001578)** and **Hemophilia B (*F9*) Deletion/Duplication (2010499)** |
| **Targeted testing for known mutation (laboratory report from family member REQUIRED)** |
| **2001961 Familial Mutation, Targeted Sequencing** - targeted testing for a known familial sequence mutation |
| **2001751 Hemophilia A (*F8*) Deletion/Duplication** - for known familial *F8* deletion/duplication |
| **2010499 Hemophilia B (*F9*) Deletion/Duplication** - for known familial *F9* deletion/duplication |

**Other test not listed: _____**

Master Label

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