

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 LOEYS-DIETZ 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 of Loeys-Dietz Syndrome (LDS)? No Yes (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Vascular | <input type="checkbox"/> Craniofacial | <input type="checkbox"/> Cutaneous | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Aortic Dilation (_____cm) | <input type="checkbox"/> Bifid uvula | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Arachnodactyly |
| <input type="checkbox"/> Arterial dissection _____ | <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Poorly formed scars | <input type="checkbox"/> Club foot |
| <input type="checkbox"/> Thoracic aneurysm | <input type="checkbox"/> Craniosynostosis | <input type="checkbox"/> Translucent skin | <input type="checkbox"/> Joint laxity |
| <input type="checkbox"/> Cerebral aneurysm | <input type="checkbox"/> Hypertelorism | <input type="checkbox"/> Velvety skin | <input type="checkbox"/> Pectus excavatum/carinatum |
| <input type="checkbox"/> Abdominal aneurysm | | | <input type="checkbox"/> Scoliosis |
- Other symptom(s):** _____

Has the patient undergone previous DNA testing? 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, clinical diagnosis, 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.**
- 2006540 Aortopathy Panel, Sequencing and Deletion/Duplication:** Confirm diagnosis of an aortopathy in individuals with aortic/vascular aneurysm, dissection, or rupture. Includes genes associated with Loeys Dietz and others associated with various aortopathies.
- 2002705 Loeys-Dietz Syndrome (TGFBR1 and TGFBR2) Sequencing:** Confirm clinical diagnosis of Loeys-Dietz syndrome.
- 2001961 Familial Mutation, Targeted Sequencing:** Tests for a previously identified familial sequencing variant. A copy of a relative's DNA laboratory result is REQUIRED.

Master Label

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