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 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)

☐ Vascular
- ☐ Aortic Dilation (_____cm)
- ☐ Arterial dissection _____
- ☐ Thoracic aneurysm
- ☐ Cerebral aneurysm
- ☐ Abdominal aneurysm

☐ Craniofacial
- ☐ Bifid uvula
- ☐ Cleft palate
- ☐ Craniosynostosis
- ☐ Hypertelorism

☐ Cutaneous
- ☐ Easy bruising
- ☐ Poorly formed scars
- ☐ Translucent skin
- ☐ Velvety skin

☐ Musculoskeletal
- ☐ Arachnodactyly
- ☐ Club foot
- ☐ Joint laxity
- ☐ Pectus excavatum/carinatum
- ☐ 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