

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 RASA1-RELATED DISORDERS TESTING

Patient Name Physician Practice Specialty Genetic Counselor	Physician Phone Physician Fax	Sex
Patient's Ethnicity (check all that apply)		
☐ African-American ☐ Asian ☐ Hisp:		
☐ Ashkenazi Jewish ☐ Caucasian ☐ Mido	dle Eastern	
<b>Does the patient have </b> $\underline{\text{symptoms}}$ <b>?</b> $\square$ No $\square$ Yes (check a	all that apply and describe)	
☐ Arteriovenous fistulaLocation(s):		
☐ Arteriovenous malformationLocation(s):		
. ,	☐ Solitary ☐ Trunk ☐ Extremities	
☐ HypertrophyLocation(s):		
☐ Other vascular malformation(s) Location: ☐ Head/face ☐ Trunk ☐ Extremities  Describe:		
☐ Parkes-Weber syndromeDescribe:		
☐ TelangiectasiaLocation(s):		
☐ TumorsDescribe:		
☐ Vein of Galen aneurysm		
☐ Other symptom(s):		
Has the patient undergone previous DNA testing?		
Is there any relevant <u>family history</u> ?		
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.		
□ 2007852 RASA1-Related Disorders (RASA1) Sequencing ar	nd Deletion/Duplication:	
Clinical sensitivity is estimated to be 70%.		
☐ 2002730 RASA1-Related Disorders (RASA1) Sequencing:  Clinical sensitivity is estimated to be 70%.		Master Label
□ 2001961 Familial Mutation, Targeted Sequencing: Tests for in a family member; a copy of relative's lab resu		

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