

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

PATIENT HISTORY FOR RASAI-RELATED DISORDERS 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)

- | | | | |
|-------------------------------------------|-------------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Does the patient have SYMPTOMS? No Yes (check all that apply)

- Capillary malformation: Multiple Solitary
 Location: Head/face Trunk Extremities
- Arteriovenous malformation (location(s): _____)
- Arteriovenous fistula (location(s): _____)
- Telangiectasia (location(s): _____)
- Vein of Galen aneurysm
- Other vascular malformation(s) Describe: _____
 Location: Head/face Trunk Extremities
- Hypertrophy (location(s): _____)
- Tumors (describe) _____
- Parkes-Weber syndrome (describe) _____
- Other _____

Does the patient have a FAMILY HISTORY of a RASAI disorder? No Yes Unknown

If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family member(s) to the patient and the symptoms/age of onset in each affected relative.

Has DNA testing been performed for these family member(s)? Yes No Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for this condition? No Yes Unknown

If yes, please describe tests(s) and results _____

Circle the RASAI test you intend to order.

2007852 RASAI-Related Disorders (RASAI) Sequencing and Deletion/Duplication

Clinical sensitivity is estimated to be 70%.

2002730 RASAI-Related Disorders (RASAI) Sequencing

Clinical sensitivity is estimated to be 70%.

2001961 Familial Mutation, Targeted Sequencing - Tests for a RASAI sequence mutation identified in a family member.

A copy of relative's DNA laboratory result is REQUIRED.

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

Master Label