ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform Familial Cerebral Cavernous Malformation (CCM) testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR FAMILIAL CEREBRAL CAVERNOUS MALFORMATION (CCM) 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 [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

Does the patient have SYMPTOMS? [ ] No [ ] Yes If yes, check all that apply

[ ] Cerebral Cavernous Malformation(s)/Angioma(s) (number): _____
[ ] Other Vascular Lesion(s) (type and location): _____
[ ] Other _____

Has the patient undergone previous DNA testing for CCM? [ ] No [ ] Yes

If yes, please check completed test(s) and provide result below or attach report.

CCM1: [ ] Sequencing [ ] Deletion/Duplication Result: _____
CCM2: [ ] Sequencing [ ] Deletion/Duplication Result: _____
CCM3: [ ] Sequencing [ ] Deletion/Duplication Result: _____

Does the patient have a FAMILY HISTORY of CCM? [ ] No [ ] Yes [ ] Unknown
If yes, **please attach PEDIGREE or** specify the RELATIONSHIP of the symptomatic family member(s) to the patient and detail the manifestations in each._____
_____
_____

Circle the test you intend to order.

2009326 Cerebral Cavernous Malformation (CCM) Panel, Sequencing and Deletion/Duplication, 3 Genes

2001961 Familial Mutation, Targeted Sequencing. A copy of a relatives genetic test result is REQUIRED.

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

Master Label