ARUP LABORATORIES

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

PATIENT HISTORY FOR VON WILLEBRAND (VWD) TESTING

Patient's 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:**

[ ] Excessive bruising [ ] Gastrointestinal bleeding [ ] Hematuria
[ ] Intracranial hemorrhage [ ] Menorrhagia [ ] Hematomas
[ ] Prolonged bleeding post surgery [ ] Post tooth extraction bleeding [ ] Other_____
[ ] Hemarthrosis [ ] Prolonged repeated nosebleeds
[ ] Prolonged repeated nosebleeds [ ] Prolonged bleeding after childbirth

Indicate disease severity in patient: [ ] N/A [ ] Mild [ ] Moderate [ ] Severe [ ] Unknown

Does the patient have a SUSPECTED DIAGNOSIS of VWD? [ ] No [ ] Yes If yes, please circle.
Type 1 Type 2A Type 2B Type 2M Type 2N Type 3 Pseudo VWD Acquired VWD

Please provide result from hemostasis factor assays:

Factor VIII:C _____%	[ ] normal	[ ] low	[ ] Unknown	[ ] Not performed
VWF:RCo (ristocetin cofactor activity)_____%	[ ] normal	[ ] low	[ ] Unknown	[ ] Not performed
VWF:Ag (quantity of antigen) _____%	[ ] normal	[ ] low	[ ] Unknown	[ ] Not performed
VWF:CB (collagen binding) _____%	[ ] normal	[ ] abnormal	[ ] Unknown	[ ] Not performed
VWF:FVIIIB (Factor VIII binding)	[ ] normal	[ ] abnormal	[ ] Unknown	[ ] Not performed
RIPA: Ristocetin-induced platelet agglutination:	[ ] normal	[ ] abnormal	[ ] Unknown	[ ] Not performed
VWF Multimer Pattern	[ ] normal	[ ] abnormal (describe)_____		

Does the patient have a FAMILY HISTORY of VWD? [ ] No [ ] Yes [ ] Unknown
If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail symptoms and age of onset.
_____

Has the patient undergone previous DNA testing for his symptoms or family history? [ ] No [ ] Yes
If yes, please describe test(s) and results_____

Circle the test you intend to order.

2005480 von Willebrand Disease, Type 2A (*VWF*) Sequencing Exon 28 with Reflex to 9 Exons; Clinical sensitivity ~ 99% for type 2A.

2005486 von Willebrand Disease, Type 2B (*VWF*) Sequencing; Clinical sensitivity ~ 80% for 2B.

2005490 von Willebrand Disease, Type 2M (*VWF*) Sequencing; Clinical sensitivity ~ 80% for type 2M.

2005494 von Willebrand Disease, Type 2N (*VWF*) Sequencing; Clinical sensitivity unknown.

2005476 von Willebrand Disease, Platelet Type (*GP1BA*) 4 Mutations; Clinical sensitivity unknown.

2001961 Familial Mutation, Targeted Sequencing: Tests for a previously identified familial mutation; copy of a relative's lab result is REQUIRED.

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

Master Label