ARUP LABORATORIES

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

PATIENT HISTORY FOR AORTOPATHY 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_____

Patient's Clinical Diagnosis [ ] Confirmed [ ] Suspected [ ] Unknown

[ ] Arterial tortuosity syndrome (ATS)
[ ] Congenital contractural arachnodactyly (CCA)
[ ] Ehlers-Danlos syndrome Type I/II, classic (EDS I/II)
[ ] Ehlers-Danlos syndrome Type IV, vascular (EDS IV)
[ ] Ehlers-Danlos syndrome Type VI, kyphoscoliotic (EDS VI)
[ ] Homocystinuria due to cystathionine beta-synthase deficiency (HCY)
[ ] Juvenile polyposis/hereditary hemorrhagic telangiectasia syndrome (JPHT)
[ ] Familial ectopia lentis
[ ] Familial thoracic aortic aneurysm (TAAD)
[ ] Loeys-Dietz syndrome (LDS)
[ ] Marfan syndrome (MFS)
[ ] Shprintzen-Goldberg syndrome
[ ] Other _____

Patient's Symptoms [ ] No [ ] Yes, check all that apply and describe

[ ] Vascular/Cardiac/Thoracic: _____
[ ] Craniofacial: _____
[ ] Cutaneous: _____
[ ] Ocular: _____
[ ] Gastrointestinal: _____
[ ] Musculoskeletal/Neurological: _____
[ ] Other_____

Is there any relevant FAMILY HISTORY? [ ] No [ ] Yes [ ] Unknown

If yes, attach a PEDIGREE or specify the relatives RELATIONSHIP to the patient. List their symptoms and age of onset.

_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
Please attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for an Aortopathy? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the genes, disorder, methodology, and results_____

Circle the test you intend to order.

2006540 Aortopathy Panel, Sequencing and Deletion/Duplication, 21 Genes. Analysis of *ACTA2, CBS, COL3A1, COL5A1, COL5A2, EFEMP2, FBN1, FBN2, FLNA, MYH11, MYLK, PLOD1, PLOD3, PRKG1, SKI, SLC2A10, SMAD3, SMAD4, TGFB2, TGFBR1, TGFBR2* genes.

2001961 Familial Mutation, Targeted Sequencing. Tests for a mutation previously identified in a family member; **copy of relative's lab result is REQUIRED**.

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

Master Label