ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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 VASCULAR MALFORMATIONS SYNDROME TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Physician: _____ **Physician Phone:** _____

Practice Specialty: _____ **Physician Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List countries of origin (if known): _____

Patient's diagnosis: ..... ☐ Confirmed ☐ Suspected ☐ Unknown

☐ Capillary malformation/arteriovenous malformation (CM-AVM)
☐ Cerebral cavernous malformation (CCM)
☐ Glomuvenous malformation (GM)
☐ Hereditary hemorrhagic telangiectasia (HHT)
☐ HHT/juvenile polyposis
☐ Multiple cutaneous and mucosal venous malformations (VMCM)
☐ Parkes Weber syndrome
☐ Proteus syndrome (PS)/Proteus-like syndrome
☐ Pulmonary arterial hypertension (PAH)
☐ PTEN hamartoma tumor syndrome (PHTS)
☐ Hereditary lymphedema
☐ Other: _____

Does the patient have symptoms/manifestations? ..... ☐ No ☐ Yes (check all that apply and describe)

☐ Telangiectasia (location(s)): _____
☐ Capillary malformations (location(s)): _____
☐ AVM(s) (location(s)): _____
☐ Cerebral cavernous malformation(s) (number): _____
☐ Venous malformation(s) (locations(s)): _____
☐ Musculoskeletal/neurological: _____
☐ Lymphedema: _____
☐ Other symptom(s): _____

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

If yes, describe the gene(s), disorder(s), methodology, and results: _____

Is there any relevant family history? ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

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.

☐ **2007384 Vascular Malformations Panel, Sequencing and Deletion/Duplication:** Preferred DNA test to confirm clinical diagnosis of a genetic-related vascular malformation disorder

☐ **3002286 Cerebral Cavernous Malformation Panel, Sequencing:** Confirm diagnosis of familial CCM in individual with suggestive findings

☐ **2009337 Hereditary Hemorrhagic Telangiectasia (HHT) Panel, Sequencing and Deletion/Duplication:** Confirm diagnosis of HHT in symptomatic individual

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

Master Label

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