ARUP LABORATORIES

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

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR VASCULAR MALFORMATIONS SYNDROME TESTING

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

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

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

List country 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) (location(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 variant testing).

Master Label

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