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 CADASIL (*NOTCH3* GENE) TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male
Physician: _____ **Physician Phone:** _____
Practice Specialty: _____ **Physician Fax:** _____
Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity (check all that apply)

☐ African American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian/White ☐ Middle Eastern ☐ Other: _____

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

☐ Ischemic Events ☐ Mood Disorders ☐ Cognitive defects ☐ Migraine with aura
☐ Stroke ☐ Depression ☐ Memory loss ☐ Seizures
☐ Transient ischemic attacks (TIA) ☐ Personality changes ☐ Attention deficits

☐ Other symptom(s): _____

Has the patient undergone an MRI for brain imaging studies? ☐ No ☐ Yes ☐ Unknown
If yes, describe results: _____

Has the patient undergone previous DNA testing for CADASIL? ☐ No ☐ Yes ☐ Unknown
If yes, describe results: _____ ☐ Normal ☐ Abnormal ☐ Unknown

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.

☐ **3000531 CADASIL: Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (*NOTCH3*), Sequencing;** Sequence analysis of NOTCH3 coding regions; clinical sensitivity 95%

☐ **2001961 Familial Mutation, Targeted Sequencing.** Tests for a mutation 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