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.

CADASIL (*NOTCH3* GENE) TESTING PATIENT HISTORY FORM

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 or Latino ☐ White ☐ Other: _____

List country of origin (if known): _____

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 variant testing)

Master Label

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