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.

CAPILLARY MALFORMATION-ARTERIOVENOUS MALFORMATION (CM-AVM) 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 ☐ White ☐ Other: _____

List countries of origin (if known):_____

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

☐ Capillary malformation:_____

☐ Multiple (number: _____) or ☐ Solitary..... Location: ☐ Head/face ☐ Trunk ☐ Extremities

☐ Arteriovenous malformation; location(s): _____

☐ Arteriovenous fistula; location(s): _____

☐ Nosebleeds; frequency: _____

☐ Telangiectasia; location(s): _____

☐ Vein of Galen malformation:_____

☐ Other vascular malformation(s): _____

..... Location: ☐ Head/face ☐ Trunk ☐ Extremities

☐ Hypertrophy; location(s): _____

☐ Lymphatic abnormality: _____

☐ Parkes-Weber syndrome: _____

☐ Other symptom(s):_____

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

If yes, describe the test(s) 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).

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

Master Label