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 fill out this form and submit it with the test request form or electronic packing list.**

# PATIENT HISTORY FOR CAPILLARY MALFORMATION-ARTERIOVENOUS MALFORMATION (CM-AVM)

**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/Black ☐ Asian ☐ Hispanic ☐ Native American

☐ Ashkenazi Jewish ☐ Caucasian/White ☐ Middle Eastern ☐ Other: _____

**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 mutation testing.)

**Check the test you intend to order.**

☐ **3001132 CM-AVM (*EPHB4* and *RASA1*) Sequencing and (*RASA1*) Deletion/Duplication:** Clinical sensitivity estimated to be at least 65% for CM-AVM.

☐ **2007852 *RASA1*-Related Disorders (*RASA1*) Sequencing and Deletion/Duplication:** Clinical sensitivity is estimated to be at least 50% for CM-AVM.

☐ **2007830 *RASA1*-Related Disorders (*RASA1*) Deletion/Duplication** Clinical sensitivity is estimated to be 5% for CM-AVM.

☐ **3001129 CM-AVM 2 (*EPHB4*) Sequencing**: Clinical sensitivity is estimated to be at least 15% for CM-AVM.

☐ **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.**