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.

PULMONARY ARTERIAL HYPERTENSION (PAH) 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 ☐ White ☐ Other: _____

Does the patient have symptoms? ..... ☐ No ☐ Yes ☐ Unknown

If yes, check all that apply:

Other: _____

Does the patient have other risk factors for pulmonary hypertension ..... ☐ No ☐ Yes ☐ Unknown

If yes, check all that apply:

☐ Lung disease ☐ Heart disease ☐ Cirrhosis

☐ Pulmonary embolism ☐ Connective tissue disease ☐ HIV

☐ Other _____

Has the patient's mean pulmonary artery pressure been measured? ..... ☐ No ☐ Yes ☐ Unknown

If yes, what was result at rest? _____mmHg ..... ☐ Normal ☐ Abnormal ☐ Unknown

What was result during exercise? _____mmHg ..... ☐ Normal ☐ Abnormal ☐ Unknown

Has the patient undergone previous DNA testing for this condition ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe the test performed 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).

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

Master Label