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.

PATIENT HISTORY FORM FOR HEREDITARY HEMORRHAGIC TELANGIECTASIA (HHT) TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ 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 country of origin (if known): _____

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

☐ Nosebleeds (frequency): _____

☐ Telangiectasia (locations): _____

☐ Capillary malformation: ☐ Multiple ☐ Solitary Location: _____

☐ Brain AVM
☐ Liver AVM
☐ Lung AVM
☐ Spinal AVM
☐ Juvenile polyps
☐ Pulmonary hypertension
☐ Stroke (age): _____

☐ Other symptom(s): _____

Has the patient undergone previous DNA testing for HHT? ..... ☐ 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 each affected 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.

For symptomatic individuals

☐ **2009337 Hereditary Hemorrhagic Telangiectasia (HHT) Panel, Sequencing and Deletion/Duplication:** Recommended diagnostic test for individuals with clinical features of HHT. Clinical sensitivity is 87% for HHT.

When an HHT gene mutation has previously been identified in a family member

☐ **2001961 Familial Mutation, Targeted Sequencing:** Recommended test for a known familial sequence variant previously identified in a family member. A copy of the relative's lab report is REQUIRED.

☐ **3003144 Deletion/Duplication Analysis by MLPA:** Recommended test for a known familial deletion or duplication in ACVRL1, ENG, or SMAD4. A copy of the relative's lab report is REQUIRED.

Master Label

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