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.

HEREDITARY HEMORRHAGIC TELANGIECTASIA (HHT) 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: _____

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 variant testing).

Master Label

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