

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

**PATIENT HISTORY FOR JUVENILE POLYPOSIS SYNDROME (JPS) /
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 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 and describe)

- Cerebral arteriovenous malformation (AVM)
- GI carcinoma (location: _____; age of diagnosis: _____)
- Hepatic AVM
- Juvenile polyposis (number of polyps: _____; location(s): _____; age of onset: _____)
- Pulmonary AVM
- Spinal AVM
- Spontaneous, recurrent nosebleeds (frequency: _____)
- Telangiectasia (location(s): _____)
- Other symptom(s): _____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant No Yes Unknown

Is there any relevant family history? No Yes Unknown

If yes, specify: JPS HHT JP/HHT Neither Unknown

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.

- 2004992 Juvenile Polyposis (*BMPR1A*) Sequencing and Del/Dup: Preferred test for confirmation of a clinical diagnosis of or predictive testing for JPS.** Clinical sensitivity 20-25% for JPS.
- 2009337 Hereditary Hemorrhagic Telangiectasia (HHT) Panel, Sequencing and Del/Dup:** Clinical sensitivity SMAD4: ~28% for JPS, unknown for JP/HHT.
- 2001961 Familial Mutation, Targeted Sequencing:** Tests for sequence variant(s) previously identified in a family member; a copy of relative's lab result is REQUIRED.
- 3003144 Deletion/Duplication Analysis by MPLA:** Tests for large deletion/duplication previously identified in a family member; a copy of a relative's lab report is REQUIRED.

Master Label

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