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 FOR HEMOPHILIA A OR B GENE 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): _____

Clinical Findings of Hemophilia: ..... ☐ None ☐ Yes (check all that apply)

☐ Chronic joint disease
☐ Excessive bruising
☐ GI bleeding/hemorrhage
☐ Hemarthrosis
☐ Intracranial hemorrhage
☐ Menorrhagia
☐ Prolonged bleeding post trauma/surgery
☐ Other: _____
☐ Spontaneous bleeding location(s): _____ _____ frequency: _____

Indicate the disease severity in this patient: ☐ N/A ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

Laboratory Findings

Factor VIII activity..... ☐ Abnormal _____ % ☐ Normal ☐ Not performed

von Willebrand factor activity..... ☐ Abnormal _____ % ☐ Normal ☐ Not performed

Factor IX activity..... ☐ Abnormal _____ % ☐ Normal ☐ Not performed

Other laboratory results: _____

Has the patient undergone previous DNA testing for hemophilia?..... ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

Is there any relevant family history of hemophilia?..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient: _____

The relative is:..... ☐ a healthy carrier ☐ affected

Attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing) or list the gene and variant(s) identified:

Check the test you intend to order.

Recommended genetic testing for Hemophilia A (F8):

☐ **2001614 Hemophilia A (F8) 2 Inversion with Reflex to Sequencing and Reflex to Deletion/Duplication**

Components available separately:

☐ **2001759 Hemophilia A (F8) 2 Inversions**

☐ **2001747 Hemophilia A (F8) Sequencing**

Recommended genetic testing for Hemophilia B (F9):

☐ **2010494 Hemophilia B (F9) Sequencing and Deletion/Duplication**

Targeted testing for known mutation (laboratory report from family member REQUIRED):

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a variant previously identified in a family member

☐ **3003144 Deletion/Duplication Analysis by MLPA:** 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.