ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, Utah 84108-1221
phone: (801) 583-2787 | toll free: (800) 242-2787
fax: (801) 584-5249 | www.aruplab.com

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

PATIENT HISTORY FOR HEMOPHILIA A OR B GENE TESTING

Patient Name _____ Date of Birth _____ Sex ☐ F ☐ M

Physician _____ Physician Phone _____

Practice Specialty _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

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

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

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 mutation(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**
☐ **2001751 Hemophilia A (F8) Deletion/Duplication**

Recommended genetic testing for Hemophilia B (F9):

☐ **2010494 Hemophilia B (F9) Sequencing and Deletion/Duplication**
Components available separately: ☐ **2001578 Hemophilia B (F9) Sequencing**
☐ **2010499 Hemophilia B (F9) Deletion/Duplication**

Master Label

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

☐ **2001751 Hemophilia A (F8) Deletion/Duplication:** For known familial F8 deletion/duplication
☐ **2010499 Hemophilia B (F9) Deletion/Duplication:** For known familial F9 deletion/duplication
☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a mutation previously identified in a family member

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