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 PULMONARY ARTERIAL HYPERTENSION (PAH) 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) ☐ Unknown

☐ Other: _____

Does the patient have other risk factors for pulmonary hypertension? .....☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Lung disease ☐ Heart disease ☐ Cirrhosis

☐ Pulmonary embolism ☐ Connective tissue disease ☐ HIV

☐ Other _____

Has the patient's mean pulmonary artery pressure been measured?.....☐ No ☐ Yes ☐ Unknown

If yes, what was result at rest? _____mmHg ..... ☐ Normal ☐ Abnormal ☐ Unknown

What was result during exercise? _____mmHg ..... ☐ Normal ☐ Abnormal ☐ Unknown

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

If yes, describe the test performed and results: _____

Is there any relevant family history .....☐ No ☐ Yes If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset: _____ ☐ Unknown

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.

☐ **2009345 Pulmonary Arterial Hypertension (PAH) Panel, Sequencing and Deletion/Duplication:** Next generation sequencing and microarray coverage of select genes associated with PAH

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for sequence variant(s) previously identified in a family member; a copy of the 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.