ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR CAPILLARY MALFORMATION-ARTERIOVENOUS MALFORMATION (CM-AVM)

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: _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply and describe)

☐ Capillary malformation: _____
☐ Multiple (number: _____) or ☐ Solitary Location: ☐ Head/face ☐ Trunk ☐ Extremities
☐ Arteriovenous malformation; location(s): _____
☐ Arteriovenous fistula; location(s): _____
☐ Nosebleeds; frequency: _____
☐ Telangiectasia; location(s): _____
☐ Vein of Galen malformation: _____
☐ Other vascular malformation(s): _____
Location: ☐ Head/face ☐ Trunk ☐ Extremities
☐ Hypertrophy; location(s): _____
☐ Lymphatic abnormality: _____
☐ Parkes-Weber syndrome: _____
☐ Other symptom(s): _____

Has the patient undergone previous DNA testing? ☐ 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 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.

☐ **3001132 CM-AVM (*EPHB4* and *RASA1*) Sequencing and (*RASA1*) Deletion/Duplication:**
Clinical sensitivity estimated to be at least 65% for CM-AVM.

☐ **2007852 *RASA1*-Related Disorders (*RASA1*) Sequencing and Deletion/Duplication:**
Clinical sensitivity is estimated to be at least 50% for CM-AVM.

☐ **2002730 *RASA1*-Related Disorders (*RASA1*) Sequencing:** Clinical sensitivity is estimated to be at least 45% for CM-AVM.

☐ **2007830 *RASA*1-Related Disorders (*RASA1*) Deletion/Duplication:** Clinical sensitivity is estimated to be 5% for CM-AVM.

☐ **3001129 CM-AVM 2 (*EPHB4*) Sequencing:** Clinical sensitivity is estimated to be at least 15% for CM-AVM.

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for an *EPHB4* or *RASA1* sequence mutation identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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