

Hereditary Hemorrhagic Telangiectasia and Vascular Malformations Gene Panel Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, and family history. To help provide the best possible service, supply the information requested below and send paperwork with the specimen or return by fax to Mayo Clinic Laboratories, Attn: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 855-379-3115 or +1-507-284-9273, or email mliintl@mayo.edu

Patient Information			
Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)	
Sex Assigned at Birth	Legal/Administrative Se) 2 Y	
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose		=	
Referring Healthcare Professional Information			
Referring Healthcare Professional Name (Last, First)	Phone	Fax*	
Genetic Counselor/Other Healthcare Professional Name (Last, First)	Phone	Fax*	
Reason for Testing *Fax number	given must be from a fax machine t	that complies with applicable HIPAA regulation	
☐ Diagnosis ☐ Family History** ☐ Other, specify:			
**Genetic testing should be performed on an affected family member first, should be ordered when there is a previous positive genetic test result in t	when possible. FMTT / Fam		
Indications			
Indications			
☐ Hereditary hemorrhagic telangiectasia (HHT) ☐ Multiple cutan	eous and mucosal venous	malformations (VMCM)	
☐ Hereditary glomuvenous malformations ☐ Capillary malfo	ormation-arteriovenous ma	alformation syndrome (CM-AVM)	
\square Familial cerebral cavernous malformation (CCM) \square Other, specify:			
Clinical History			
☐ Telangiectasia		Cerebral cavernous malformation	
Location and number:		Number:	
☐ Epistaxis (nosebleeds)		☐ Retinal vascular malformation	
Frequency:		Parkes-Weber syndrome	
☐ Visceral arteriovenous malformations (AVM)		•	
Location and number:			
☐ Arteriovenous (AV) fistula			
Location and number:			
☐ Capillary malformations			
Location and number:			
Patient's phenotype meets consensus clinical diagnostic (Curaçao) criteria fo	or HHT:		
Other Relevant Clinical History			

Hereditary Hemorrhagic Telangiectasia and Vascular Malformations Gene Panel Patient Information (continued)

or Informed Consent for Genetic Testing - Spanish (T826).

Patient Name (Last, First Middle)		•			Birth Date (mm-dd-yyyy)		
Family History							
Are there similarly affected rela	atives?	☐ Yes	□ No				
If "Yes," indicate relationship and symptoms:							
Have any family member had genetic testing? ☐ Yes*** ☐ No ☐ Unknown							
***FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.							
History of consanguinity: No Yes; relationship details:							
Ancestry							
☐ African/African American	☐ East Asian	☐ Lat	inx/Latine	☐ South Asian	☐ Choose not to disclose		
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern		\square None of the above	□ Unknown		
New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576)							

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