Complete and print.

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MAYO CLINIC LABORATORIES

Hereditary Hemorrhagic Telangiectasia and Vascular Malformations Gene Panel Patient Information

Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, family history, and ancestry. 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: 800-533-1710 / International clients: 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)
Preferred Name	Medical Record Number (if Birth Date is not available)
Sex Assigned at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other, specify:	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary ☐ Choose not to disclose ☐ Other, specify:
Gender Identity (optional)	Pronouns (optional)

Referring Healthcare Professional Information

Referring Healthcare Professional Name (Last, First)	Phone	Fax*
Genetic Counselor/Other Healthcare Professional Name (Last, First)	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

☐ Diagnosis ☐ Biological Family History** ☐ Other, specify:

**Genetic testing should be performed on an affected biological family member first, when possible. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

Indications

Indications

☐ Hereditary hemorrhagic telangiectasia (HHT)
☐ Hereditary glomuvenous malformations
☐ Familial cerebral cavernous malformation (CCM)
☐ Multiple cutaneous and mucosal venous malformations (VMCM)
☐ Capillary malformation-arteriovenous malformation syndrome (CM-AVM)
☐ Other, specify:

Clinical History

☐ Telangiectasia
Location and number:

☐ Epistaxis (nosebleeds)
Frequency:

☐ Visceral arteriovenous malformations (AVM)
Location and number:

☐ Arteriovenous (AV) fistula
Location and number:

☐ Capillary malformations
Location and number:

☐ Cerebral cavernous malformation
Number:

☐ Retinal vascular malformation

☐ Parkes-Weber syndrome

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

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)

Clinical History (continued)

Patient's phenotype meets consensus clinical diagnostic (Curaçao) criteria for HHT: ☐ Yes ☐ No

Other Relevant Clinical History

Biological Family History

Are there similarly affected biological relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any biological family members 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 ☐ Unknown ☐ Choose not to disclose

☐ Yes; relationship details:

Patient Ancestry

Ancestry: ☐ Unknown ☐ Choose not to disclose

New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576) or Informed Consent for Genetic Testing – Spanish (T826).

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