



Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, 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: Personalized Genomics Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email mclglobal@mayo.edu**

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact Name <i>(Last, First)</i>	Phone	Fax*

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

Reason for Referral

--

Clinical History Check all that apply.

Pertinent Clinical and Laboratory History

Telangiectasia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location and/or number: <input type="checkbox"/> Lips _____ <input type="checkbox"/> Oral Cavity _____ <input type="checkbox"/> Fingers _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> GI mucosa _____
Nosebleeds? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Frequency _____
Visceral AVMs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location and/or number: <input type="checkbox"/> Hepatic _____ <input type="checkbox"/> Cerebral _____ <input type="checkbox"/> Pulmonary _____ <input type="checkbox"/> Spinal _____ <input type="checkbox"/> Gastrointestinal _____
AV Fistula? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location: <input type="checkbox"/> Dural _____ <input type="checkbox"/> Cerebral _____ <input type="checkbox"/> Spinal _____ <input type="checkbox"/> Other _____
Juvenile polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Parkes Weber syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other relevant clinical information (surgeries, etc.): _____

Ethnic Background Ethnic background is necessary to provide appropriate interpretation of test results.

<input type="checkbox"/> Northern European Caucasian <input type="checkbox"/> Mixed European Caucasian <input type="checkbox"/> Southern European Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other (specify): _____ Indicate countries of origin if available: _____
--

Family History Include a detailed pedigree, if available.

Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate their relationship to the patient.
Have other relatives had molecular genetic testing for HHT? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the performing laboratory and attach a copy of the genetic test lab report if available:
If the relative was tested at Mayo Clinic, include the name of the family member:	
For known mutation test requests, order known variant analysis: KVAR1 / Known Variant Analysis-1 Variant; KVAR2 / Known Variant Analysis-2 Variants; KVAR3 / Known Variant Analysis-3+ Variants	

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).