

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform Loeys-Dietz testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR LOEYS-DIETZ TESTING

Patient's Name _____ Date of Birth ____/____/____ Gender F M

Physician _____ Physician Phone (____) _____ Practice specialty _____

Genetic Counselor _____ Counselor Phone (____) _____

Patient's Ethnicity (check all that apply)

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Does the patient have SYMPTOMS? No Yes (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hypertelorism | <input type="checkbox"/> Translucent skin | <input type="checkbox"/> Thoracic aneurysm |
| <input type="checkbox"/> Arachnodactyly | <input type="checkbox"/> Craniosynostosis | <input type="checkbox"/> Velvety skin | <input type="checkbox"/> Cerebral aneurysm |
| <input type="checkbox"/> Club foot | <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Poorly formed scars | <input type="checkbox"/> Abdominal aneurysm |
| <input type="checkbox"/> Joint laxity | <input type="checkbox"/> Bifid uvula | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Arterial dissection _____ |
| <input type="checkbox"/> Pectus excavatum/carinatum | <input type="checkbox"/> Aortic Dilation (____cm) | <input type="checkbox"/> Other _____ | |

Does the patient have a FAMILY HISTORY of Loeys-Dietz Syndrome? No Yes Unknown

If yes, **please attach PEDIGREE** or specify the RELATIONSHIP of the family member(s) to the patient and detail the symptoms/age of onset in each symptomatic/affected relative. _____

Please attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing)

Has the patient undergone previous DNA testing for Loeys-Dietz Syndrome? No Yes Unknown

If yes, please describe test(s) and results _____

Circle the Loeys-Dietz test that you intend to order.

2002701 Loeys-Dietz Syndrome (*TGFBR1* and *TGFBR2*) Sequencing and Deletion/Duplication

Clinical sensitivity is at least 95%.

2002705 Loeys-Dietz Syndrome (*TGFBR1* and *TGFBR2*) Sequencing

Clinical sensitivity is 95%.

2002697 Loeys-Dietz Syndrome (*TGFBR1* and *TGFBR2*) Deletion/Duplication

Clinical sensitivity is unknown.

2001961 Familial Mutation, Targeted Sequencing

Tests for a previously identified familial mutation. A copy of a relative's DNA laboratory result is REQUIRED.

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

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