ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform *RASA1* gene testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR *RASA1*-RELATED DISORDERS 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)

[ ] African-American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

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

[ ] Capillary malformation: [ ] Multiple [ ] Solitary
Location: [ ] Head/face [ ] Trunk [ ] Extremities
[ ] Arteriovenous malformation (location(s): _____)
[ ] Arteriovenous fistula (location(s): _____)
[ ] Telangiectasia (location(s): _____)
[ ] Vein of Galen aneurysm
[ ] Other vascular malformation(s) Describe:_____
Location: [ ] Head/face [ ] Trunk [ ] Extremities
[ ] Hypertrophy (location(s): _____)
[ ] Tumors (describe) _____)
[ ] Parkes-Weber syndrome (describe) _____)
[ ] Sturge-Weber syndrome (describe) _____)
[ ] Klippel-Trenaunay-Weber syndrome (describe) _____)
[ ] Other_____

Does the patient have a FAMILY HISTORY of a *RASA1* disorder? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the RELATIONSHIP of the family member(s) to the patient and the symptoms/age of onset in each affected relative.

_____

_____

Has DNA testing been performed for these family member(s)? [ ] Yes [ ] No [ ] Unknown
If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Has the patient undergone previous DNA testing for this condition? [ ] No [ ] Yes [ ] Unknown
If yes, please describe tests(s) and results _____

Circle the *RASA1* test you intend to order.

2002730 *RASA1*-Related Disorders (*RASA1*) Sequencing: Sequencing of the *RASA1* gene for capillary malformation-arteriovenous malformation syndrome, Parkes-Weber syndrome, and other *RASA1*-related conditions. Order for patients with a definite or suspected clinical diagnosis.

2001961 Familial Mutation, Targeted Sequencing
Tests for a *RASA1* mutation identified in a family member. A copy of relative's DNA laboratory result is REQUIRED.

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

Master Label