

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

PATIENT HISTORY FOR VON WILLEBRAND (VWD) 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 **If yes, check all that apply:**

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Excessive bruising | <input type="checkbox"/> Gastrointestinal bleeding | <input type="checkbox"/> Hematuria |
| <input type="checkbox"/> Intracranial hemorrhage | <input type="checkbox"/> Menorrhagia | <input type="checkbox"/> Hematomas |
| <input type="checkbox"/> Prolonged bleeding post surgery | <input type="checkbox"/> Post tooth extraction bleeding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hemarthrosis | <input type="checkbox"/> Prolonged repeated nosebleeds | |
| <input type="checkbox"/> Prolonged repeated nosebleeds | <input type="checkbox"/> Prolonged bleeding after childbirth | |

Indicate disease severity in patient: N/A Mild Moderate Severe Unknown

Does the patient have a SUSPECTED DIAGNOSIS of VWD? No Yes **If yes, please circle.**

Type 1 Type 2A Type 2B Type 2M Type 2N Type 3 Pseudo VWD Acquired VWD

Please provide result from hemostasis factor assays:

- | | | | | |
|--|---------------------------------|--|----------------------------------|--|
| Factor VIII:C _____% | <input type="checkbox"/> normal | <input type="checkbox"/> low | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| VWF:RCo (ristocetin cofactor activity) _____% | <input type="checkbox"/> normal | <input type="checkbox"/> low | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| VWF:Ag (quantity of antigen) _____% | <input type="checkbox"/> normal | <input type="checkbox"/> low | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| VWF:CB (collagen binding) _____% | <input type="checkbox"/> normal | <input type="checkbox"/> abnormal | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| VWF:FVIII(B (Factor VIII binding) | <input type="checkbox"/> normal | <input type="checkbox"/> abnormal | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| RIPA: Ristocetin-induced platelet agglutination: | <input type="checkbox"/> normal | <input type="checkbox"/> abnormal | <input type="checkbox"/> Unknown | <input type="checkbox"/> Not performed |
| VWF Multimer Pattern | <input type="checkbox"/> normal | <input type="checkbox"/> abnormal (describe) _____ | | |

Does the patient have a FAMILY HISTORY of VWD? No Yes Unknown

If yes, specify the RELATIONSHIP of the family member(s) to the patient and detail symptoms and age of onset.

Has the patient undergone previous DNA testing for his symptoms or family history? No Yes

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

Circle the test you intend to order.

2005480 von Willebrand Disease, Type 2A (VWF) Sequencing Exon 28 with Reflex to 9 Exons; Clinical sensitivity ~ 99% for type 2A.

2005486 von Willebrand Disease, Type 2B (VWF) Sequencing; Clinical sensitivity ~ 80% for 2B.

2005490 von Willebrand Disease, Type 2M (VWF) Sequencing; Clinical sensitivity ~ 80% for type 2M.

2005494 von Willebrand Disease, Type 2N (VWF) Sequencing; Clinical sensitivity unknown.

2005476 von Willebrand Disease, Platelet Type (GP1BA) 4 Mutations; Clinical sensitivity unknown.

2001961 Familial Mutation, Targeted Sequencing: Tests for a previously identified familial mutation; copy of a relative's lab result is REQUIRED.

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

Master Label