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MAYO CLINIC LABORATORIES

Hereditary Hemorrhagic Telangiectasia and Vascular Malformations Gene Panel Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, 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: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

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

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

Referring Provider Name *(Last, First)*	Phone	Fax*
Other Contact Name *(Last, First)*	**Phone**	**Fax***

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

Reason for Testing

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

**Genetic testing should be performed on an affected family member first, when possible. FMTT / Familial Mutation 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

Other Relevant Clinical History

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

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

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any family member had genetic testing? ☐ Yes*** ☐ No ☐ Unknown

*****FMTT / Familial Mutation 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 ☐ Yes; relationship details:

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Choose not to disclose
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Unknown

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).

Print