MAYO CLINIC
Mayo Medical Laboratories

# *Hereditary Hemorrhagic Telangiectasia (HHT) Gene Testing*

H H T G T

## Patient Information Sheet

**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, please supply the information requested below and **send paperwork with the specimen.**

## Patient Information

| Patient Name *(First, Middle, Last)* | | Birth Date *(Month DD, YYYY)* | Sex ☐ Male ☐ Female |
|---|---|---|---|
| Refering Physician Name | Phone Number | Fax Number | |
| Other Contact | Phone Number | Fax Number | |

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

## Study Purpose

Study Purpose: ☐ Diagnostic ☐ Presymptomatic

## HHT Known Mutation (if applicable)

If 89391 ENG Gene Known Mutation, or 89393 ACVRL1 Gene Known Mutation is ordered, the following information must be provided or testing cannot be completed:

Known familial mutation to be analyzed:

Proband's relationship to patient:

## HHT Deletion/Duplication Detection (if applicable)

If 89587 ENG and ACVRL1, Large Del/Dup is ordered for familial mutation testing, the following information must be provided or testing cannot be completed:

Familial deletion or duplication:

Proband's relationship to patient:

## Clinical History (check all that apply)

**Pertinent Clinical and Laboratory History**

**Telangiectasia(s)?** ☐ Yes ☐ No ☐ Unknown
Location and/or number: ☐ Lips_____ ☐ Oral Cavity_____ ☐ Fingers_____ ☐ Nose_____ ☐ GI mucosa_____

**Nosebleed(s)?** ☐ Yes ☐ No ☐ Unknown Frequency_____

**Visceral AVM(s)?** ☐ Yes ☐ No ☐ Unknown
Location and/or number: ☐ Hepatic _____ ☐ Cerebral _____ ☐ Pulmonary_____ ☐ Spinal _____ ☐ Gastrointestinal_____

**Juvenile polyps?** ☐ Yes ☐ No ☐ Unknown

Other relevant clinical information (surgeries, etc.):

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

☐ Northern European Caucasian ☐ Mixed European Caucasian ☐ Southern European Caucasian
If Caucasian, indicate countries of origin: _____
☐ African American ☐ Hispanic ☐ Asian
☐ French Canadian ☐ African American ☐ Other (specify):_____

**Family History**

| Are other relatives known to be affected? ☐ Yes ☐ No | If yes, indicate their relationship to the patient. |
|---|---|
| Have other relatives had molecular genetic testing for HHT? ☐ Yes ☐ No | If yes, please 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:

**Please include a detailed pedigree, if available.**



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