Complete and print.

MAYO CLINIC LABORATORIES

Hereditary Hemorrhagic Telangiectasia (HHT) Gene Testing Patient Information

H H T G T

Reset Form

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, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Personalized Genomics Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email mclglobal@mayo.edu**

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
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 regulation.*

Reason for Testing

Clinical History Check all that apply.

Pertinent Clinical and Laboratory History

Telangiectasia? ☐ Yes ☐ No ☐ Unknown
Location and/or number: ☐ Lips _____ ☐ Oral Cavity _____ ☐ Fingers _____ ☐ Nose _____ ☐ GI mucosa _____

Nosebleeds? ☐ Yes ☐ No ☐ Unknown Frequency _____

Visceral AVMs? ☐ Yes ☐ No ☐ Unknown
Location and/or number: ☐ Hepatic _____ ☐ Cerebral _____ ☐ Pulmonary _____ ☐ Spinal _____ ☐ Gastrointestinal _____

AV Fistula? ☐ Yes ☐ No ☐ Unknown
Location: ☐ Dural _____ ☐ Cerebral _____ ☐ Spinal _____ ☐ Other _____

Juvenile polyps? ☐ Yes ☐ No ☐ Unknown

Parkes Weber syndrome? ☐ Yes ☐ No

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
☐ African American ☐ Hispanic ☐ Asian ☐ Middle Eastern
☐ Other (specify): _____
Indicate countries of origin if available: _____

Family History Include a detailed pedigree, if available.

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, 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:	
For known mutation test requests, order known variant analysis: KVAR1 / Known Variant Analysis-1 Variant, Varies; KVAR2 / Known Variant Analysis-2 Variants, Varies; KVAR3 / Known Variant Analysis-3+ Variants, Varies	

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