Complete and print.

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MAYO CLINIC LABORATORIES

von Willebrand Disease Patient Information

Instructions: von Willebrand factor *(VWF)* gene testing for von Willebrand disease (vWD) should only be considered if there is supportive patient and/or family history, and the results of specialized VWF quantitative or functional assays suggest a diagnosis of vWD. If not performed locally, testing through Mayo Clinic Laboratories is available; order AVWPR / von Willebrand Disease Profile, Plasma. Providing this clinical information and results of coagulation testing is critical to ensure accurate interpretation and reporting of genetic test results. For the best possible service, supply the information requested below and **send this paperwork with the specimen or return by fax to 507-284-1759**.

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Genetic Counselor/Nurse Name *(Last, First)*	Phone	Fax*

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

Reason for Testing

Clinical Information

Clinical Diagnosis (select one): von Willebrand Disease
☐ Unknown ☐ Type 1 ☐ Type 2A ☐ Type 2B ☐ Type 2M ☐ Type 2N ☐ Type 3

Relevant Clinical Presentation (attach case notes, if available): _____

Relevant Laboratory Findings (attach all coagulation results, if available): _____

PT: _____ Normal range: _____		von Willebrand factor activity by latex immunoassay:	Factor VIII activity (FVIII:C):
aPTT: _____ Normal range: _____		Multimer distribution:	
Platelet count:		Collagen binding:	
von Willebrand Factor Antigen (vWF:Ag):	von Willbrand Factor Activity (vWF:Ac):	Ristocetin-induced platelet aggregation (RIPA) or platelet binding:	
von Willebrand Activity/Ristocetin Cofactor Activity (vWF:RCo):		Factor VIII binding (vWF:FVIIIB):	
Platelet vWF studies:		Previous genetic testing of the *VWF* gene (attach copy of test results, if available:	

Has patient had an allogenic bone marrow transplant? ☐ Yes** ☐ No If Yes, transplant date *(mm-dd-yyyy)*: _____

Previous testing at Mayo? ☐ Yes ☐ No If Yes, specify: _____

** A previous bone marrow transplant from an allogenic donor will interfere with testing. Call 800-533-1710 for instructions for testing patients who have received a bone marrow transplant.

Pregnancy Information Prenatal/cord blood specimen also requires maternal blood with order for MATCC.

Is patient or partner currently pregnant? ☐ Yes ☐ No
If yes, weeks gestation: _____

Prenatal specimen? ☐ Yes ☐ No
If yes, specify specimen type: ☐ Chorionic villus sampling ☐ Amniotic fluid

Cord blood specimen? ☐ Yes ☐ No

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von Willebrand Disease Patient Information (continued)

Family History Include a detailed pedigree, if available.

Are there relatives known to be affected by or carriers of a bleeding or clotting disorder? ☐ Yes ☐ No ☐ Unknown

If Yes, indicate relationship (including degree) to patient or attach pedigree: _____

Have other relatives had molecular genetic testing for a bleeding or clotting disorder? ☐ Yes ☐ No ☐ Unknown

If Yes, provide results and attach a copy of the genetic test lab report, if available: _____

If the relative was tested at Mayo Clinic, include the family member name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*

Ethnic Background Ethnic background may assist with interpretation of test results. Check all that apply.

☐ African	☐ East Asian	☐ European	☐ Jewish
☐ Latino	☐ Southeast Asian	☐ Other, specify: _____	

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).

Visit www.MayoClinicLabs.com for the most up-to-date test and shipping information.

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