impact genetics

LAB USE ONLY DO NOT FILL OUT

Date received: Y M D

Specimen type:

Condition:

MRN: Tech:

Form 1b: HHT Genetic Test Requisition

Patient

Last name:

First name:

Date of birth: Y M D

Gender: ☐ Male ☐ Female

Pregnant: ☐ Yes ☐ No

Expected delivery date: Y M D

Patient History

☐ Confirmed clinical diagnosis

☐ Suspected clinical diagnosis ☐ Unaffected

Symptoms:

☐ PAVM ☐ Rare nose bleeds ☐ Liver shunts

☐ CAVM ☐ Frequent nose bleeds ☐ Stroke

☐ Telangiectasia ☐ Other:

Family History

☐ Isolated case ☐ Positive family history

Family previously tested: ☐ Yes ☐ No

Mutation identified: ☐ Yes ☐ No

If mutation identified at lab other then Impact Genetics please provide report.

Proband name (first person in a family to be studied):

Mutation:

Relationship To Proband

☐ Proband ☐ Parent of proband

☐ Brother or sister of proband ☐ Child of proband

☐ Other:

Specimen Information

Sample:

☐ Blood sample for DNA

☐ Blood sample for RNA (at Impact Genetics' request)

☐ DNA from blood ☐ DNA from tumor

☐ Fresh tumor ☐ Frozen tumor

☐ Buccal swab (only for preapproved familial mutation confirmation, contact lab directly before submitting)

☐ Other:

Pre-natal:

☐ Cord blood ☐ CVS ☐ Cultured amniocytes

☐ Direct amniotic fluid ☐ DNA extracted from CVS

☐ DNA extracted from amniocytes

Date of collection: Y M D

Time of collection: HH:MM (24hr)

☐ Sample to test maternal cell contamination

Referring Specialist

Name:

Specialty:

Contact:

Telephone: Fax:

Email:

Signature:

Institution:

Address:

City: Prov/State:

Postal code: Country:

Additional copies to:

Email: Fax:

Pedigree

Please complete the following page for detailed family history information if available.

Billing

Impact Genetics tests ordered through LabCorp test menu.
USA only.

☐ a) Client Bill

Provide details:

☐ b) Patient Pay

*Complete **LabCorp Financial Responsibility Form**.*

☐ c) Third party insurance (USA only)

*Complete **Form 1c:** U.S. Insurance Information and to expedite testing, complete **LabCorp Financial Responsibility Form**.*

1100 Bennett Road - Unit 4, Bowmanville, ON L1C 3K5
t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786
e: info@impactgenetics.com *Please ensure to use secure email*

impact genetics

HHT Genetic Test Requisition: Family History Information

Proband name: ______________________ **Date of birth:** Y ____ M ____ D ____

Enter family members starting with the proband's parents and then brothers/sisters and biological children.
Use additional sheets as needed to provide information on additional affected family members.

Name of Family Member / Relationship to Proband	Symptoms (*Please check all applicable boxes* ☑)		
Name: ____ Relationship: ____ Date of birth: Y ____ M ____ D ____ Carries HHT mutation? ☐ Yes ☐ No ☐ Unknown	☐ PAVM ☐ CAVM ☐ Rare nose bleeds ☐ Frequent nose bleeds	☐ GI bleeding ☐ Telangiacteses ☐ Liver shunts ☐ Stroke	☐ Unaffected ☐ Other (list below): ____ ____
Name: ____ Relationship: ____ Date of birth: Y ____ M ____ D ____ Carries HHT mutation? ☐ Yes ☐ No ☐ Unknown	☐ PAVM ☐ CAVM ☐ Rare nose bleeds ☐ Frequent nose bleeds	☐ GI bleeding ☐ Telangiacteses ☐ Liver shunts ☐ Stroke	☐ Unaffected ☐ Other (list below): ____ ____
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