



**IGADM 1100 A
HHT Test Additional Information
Request Form**

THE BELOW INFORMATION IS CONSIDERED PRIVATE AND CONFIDENTIAL

URGENT! This regards a recently received **HHT Relative** test request (code **480192**) for your patient:

NAME: _____ DOB (YYYY-MM-DD) _____

MRN/LABCORP# (if applicable): _____

YOU HAVE REQUESTED HHT RELATIVE TESTING, A TARGETED CARRIER TEST. TESTING CANNOT PROCEED UNTIL ONE OF THE OPTIONS BELOW HAVE BEEN SELECTED:

- The patient's family has had prior genetic testing and we will provide Impact Genetics a copy of the family's genetic report.
- The patient's family has had prior genetic testing. The specific genetic mutation is provided below:
Genetic variant information: _____
- The patient does not have any HHT mutation information available and would still like to proceed with a **HHT Proband** test (code **480074**) to screen their DNA for any potential pathogenic variants. The patient is aware that there is a higher cost to this screening test compared to targeted carrier testing. The patient or clinic will contact Labcorp to update the test request.
- Our patient and clinic require more time to obtain the variant information details. Please hold the patient specimen until we provide Impact Genetics with the variant information.
- Our patient wishes to cancel the test immediately. Please dispose their sample.

Please sign and date this form below, then fax the completed form to **Impact Genetics** at **905-697-9786**. Be sure to contact your local Labcorp affiliate to update the patient's requisition and billing information as required.

Form completed by: _____ Date (YYYY-MM-DD): _____

Title: _____ Affiliate/Clinic: _____

For any questions/comments, please contact our laboratory:



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