HOPITAL LARIBOISIERE
LABORATOIRE D'HISTO-EMBRYO-CYTOGENETIQUE
Prof. E. TOURNIER-LASSERVE

INFORMATION SHEET TO BE COMPLETED WHEN REQUESTING DIAGNOSTIC TESTING FOR CEREBRAL CAVERNOUS MALFORMATIONS

(Enclose a detailed hospital chart)

Patient's first nam: Last name:
Maiden name:
Date of birth: Age:

Clinical signs

- Age at clinical onset:
  Nature of 1st clinical sign:

- Other signs observed **in the patient:**

Headaches	yes – no
Epilepsy	yes – no
Intra cerebral haemorrhage	yes – no
Hyperkeratotic cutaneous angioma	yes – no
Retinal cavernoma	yes – no

- Existence of **relatives affected** or who have clinical signs compatible with the presence of cavernous malformations: yes – no
  (Last name of affected relatives if different from patient's name)

Imaging:

Enclose a copy of the MRI scans

Surgical treatment: yes – no Pathology results: yes-no

Family tree: