HEARTGENETICS
GENETICS & BIOTECHNOLOGY

Taguspark, Parque de Ciência e Tecnologia,
Edifício Inovação II, 421, 2740-122 Oeiras
+351 263 974 652 | contact@heartgenetics.com |
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MOLECULAR TEST REQUISITION FORM

MOLECULAR PATHOLOGIC MARKERS FOR HYPERTROPHIC CARDIOMYOPATHY

INDEX PATIENT/ FAMILIAR INFORMATION (obligatory field, delete as applicable)

Name: _____; Date of birth: _____

Gender: ☐ M ☐ F Ethnicity and geographical origin: - from index patient _____; - from the mother _____, - from the father _____ Consultancy Referral Number: _____

Identification Label / Barcode

Place the identification label here

SPECIMEN SOURCE (obligatory field)

☐ Whole blood ☐ DNA ☐ Saliva

URGENT ☐
Reason: _____

PHYSICIAN INFORMATION (obligatory field)

Physician _____

Address _____

Institution: _____ Department: _____

Telephone: _____ Fax: _____ E-mail: _____

MOLECULAR TEST REQUESTED (obligatory field)

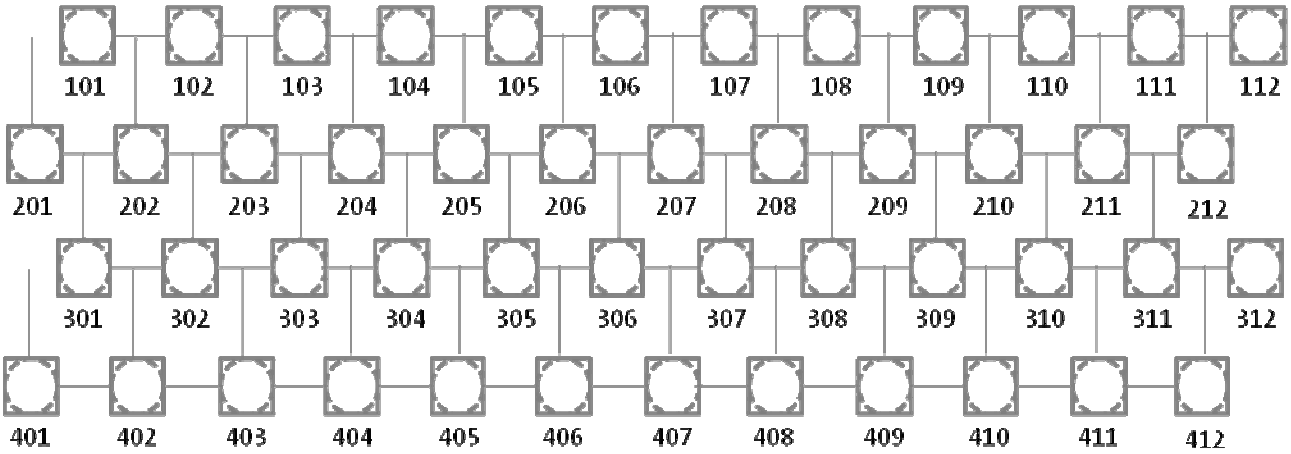
Genetic evaluation of molecular pathologic markers for hypertrophic cardiomyopathy ☐

Evaluation of genetic mutations in 9 genes (*ACTC1*, *MYH7, MYBPC3, MYL3, TNNT2, TNNI3, TNNC1, TPM1, TCAP)* associated with a severe phenotype of hypertrophic cardiomyopathy and that are related with the cardiac contraction mechanism that comprise the dysfunction of the 1) mechanical kinetics between sarcomeric proteins; 2) biochemical sensitivity to calcium and 3) cell bioenergetics related with myosin ATPase activity.

PREVIOUS GENETIC CONSULTANCY: Date ____/_____/____; **AGE OF DIAGNOSTIC:** __

FAMILIAR INFORMATION

Previously studied familial members: identification in genealogical tree. Point out the individual in the present study with an arrow (↗).



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Name: _____

Consultancy Referral Number: _____

Position in the tree	Name / Consultancy Referral Number	Clinical information and age of diagnostic

CLINICAL INFORMATION

COMPLEMENTARY DIAGNOSTIC EXAMS

_____

_____

THERAPEUTICS

_____

_____

ANNEX

☐ Sample tubes labeled with index case / patient / familiar information

☐ Whole blood (preferable) (Date obtained: ____ / ____ / ___), Conditions: 4mL or 2 X 3mL in K_2EDTA or K_3EDTA collection tube

☐ DNA (Date obtained: ___ / ___ / ___); Volume ____µL; Concentration _____ µg/mL; Purification Method: _____;
Conditions: minimum 300ng of 35ng/µL,

☐ Saliva (recommended kit: Ex: Oragene DNA collection kit Genotek)

INFORMED CONSENT INFORMATION (IT IS MANDATORY TO BE SIGNED)

I hereby authorize the collection of my/ my child´s ..... [name] biological sample for the genetic test specified in this request. I declare that I have been informed about genetic testing features and that I understand the benefits and limitations of the cardiovascular genetic test regarding genetic analysis of hypertrophic cardiomyopathy for which I am giving permission.

I give permission for the anonymously processing of the obtained digital data: yes ☐ no ☐
I give permission for the biological specimen and clinical information to be anonymously used in research studies: yes☐ no ☐

Place and Date _____;____/____/ 20___ **Signature** _____

Physician signature _____