HEARTGENETICS
GENETICS & BIOTECHNOLOGY

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

MOLECULAR TEST REQUISITION FORM

FAMILIAL GENETIC TEST

FAMILIAL INFORMATION (obligatory field, delete as applicable)

Name: _____; Date of birth : _____;
Gender: ☐ M ☐ F Ethnicity and geographical origin: - from familial _____;
- 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: _____Departament:_____
Telephone: _____ Fax: _____ E-mail: _____

MOLECULAR TEST REQUESTED (obligatory field)

Testing for a previously identified familial mutation ☐
Gene _____ , Genetic variant to be evaluated _____

Pathology to be evaluated: Thrombophilia ☐ , Molecular risk markers for arterial hypertension ☐ , Hypertrophic cardiomyopathy ☐ , Arrhythmogenic Right Ventricular Cardiomyopathy ☐ , Dilated Cardiomyopathy ☐ , Brugada Syndrome ☐ Long QT Syndrome ☐ , Short QT Syndrome ☐ , Leopard Syndrome ☐ , Noonan Syndrome and associated Syndromes ☐ , Marfan Syndrome and associated Syndromes ☐, Familial hypercholesterolemia ☐

PREVIOUS GENETIC CONSULTANCY: Date _____/_____/_____,
REASONS FOR TESTING: Diagnosis ☐ , Presymptomatic diagnosis ☐ , Carrier testing ☐
Was the family member (index patient) with the known mutation tested at HeartGenetics?
☐ No. Please attach a copy of the original index case report.
☐ Yes, please complete the following:
Familial relationship with index patient: _____ Index Patient Name _____
Date of birth : _____; Gender: ☐ M ☐ F

HEARTGENETICS
GENETICS & BIOTECHNOLOGY

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

MOLECULAR TEST REQUISITION FORM

FAMILIAL GENETIC TEST

Name: _____

Consultancy Referral Number: _____

CLINICAL INFORMATION

COMPLEMENTARY DIAGNOSTIC EXAMS

_____

_____

THERAPEUTICS

_____

_____

ANNEX

☐ Sample tubes labeled with familial 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: 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 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 _____