

MOLECULAR TEST REQUISITION FORM
GENETIC EVALUATION OF THROMBOPHILIA

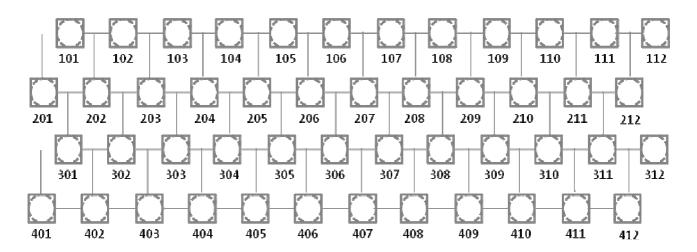
Taguspark, Parque de Ciência e Tecnologia, Edifício Inovação II, 421, 2740-122 Oeiras +351 263 974 652 | contact@heartgenetics.com | www.heartgenetics.com

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

Previously studied familial members: identification in genealogical tree. Point out the individual in the present study with a 🗸.





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	Na	ame:
	Co	onsultancy Referral Number:
Position in the tree	Name / Consultancy Referral Number	Clinical information and data of diagnostic
CLINICAL INC	ODMATION	
CLINICAL INFO	ORMATION	
OMPLEMENTARY	DIAGNOSTIC EXAMS	
HERAPEUTICS		
ANNEX		
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	ained: / /); V num 300ng of 35ng/µL,	/olumeµL; Concentration μg/mL; Purification Method:
Saliva, Conditio	ns: Ex: Oragene DNA collection	n kit Genotek
INFORMED CO	NSENT INFORMATION	N (IT IS MANDATORY TO BE SIGNED)
	specified in this request.	child's[name] biological sample I declare that I have been informed about genetic testing features and that I he cardiovascular genetic test regarding genetic analysis of thrombophilia for
-	ermission.	
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nderstand the be hich I am giving p give permission fo	or the processing of the obt	tained digital data: yes $\ \square$ no $\ \square$ and clinical information to be used in genetic research studies: yes $\ \square$ no $\ \square$
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Physician signature _____