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

GENETIC ANALYSIS OF HYPERTROPHIC CARDIOMYOPATHY

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

Name: _____; Age: _____; 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; ☐ Cells collected from buccal swab or saliva; ☐ Other _____

URGENT ☐
Reason: _____

PHYSICIAN INFORMATION (obligatory field)

Physician _____

Address_____

Institution: _____Department:_____

Telephone: _____ Fax: _____ E-mail: _____

MOLECULAR TEST REQUESTED (obligatory field)

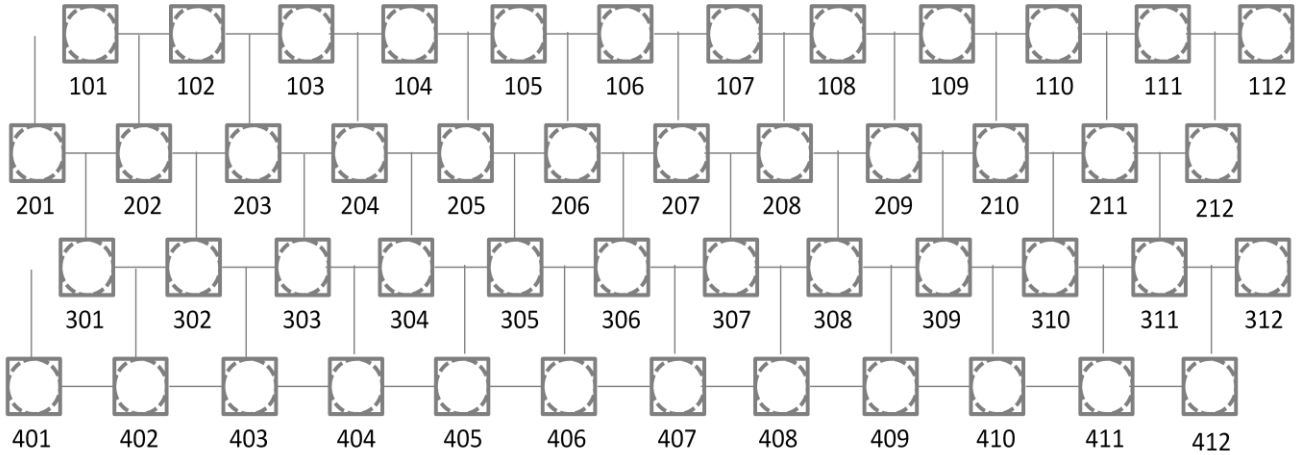
Genetic evaluation of hypertrophic cardiomyopathy ☐

Evaluation of genetic alterations that are associated with Hypertrophic Cardiomyopathy, in particular that are related with cardiac contraction mechanism and 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. In this context are evaluated 957 genetic variants in 53 genes associated with hypertrophic cardiomyopathy.

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 a ↗.



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Name: _____

Consultancy Referral Number: _____

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

CLINICAL INFORMATION: COMPLEMENTARY DIAGNOSTIC EXAMS

_____

_____

_____

THERAPEUTICS

_____

_____

ANNEX

☐ Sample tubes labeled with patient / familiar information

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

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

☐ Cells collected from buccal swab or saliva, Conditions: 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 processing of the obtained digital data: yes ☐ no ☐

I give permission for the biological specimen and clinical information to be used in genetic research studies: yes ☐ no ☐

Date	Patient signature	Physician signature
____/____/ 20___	_____	_____