HEARTGENETICS
GENETICS & BIOTECHNOLOGY

Taguspark, Parque de Ciência e Tecnologia,
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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)

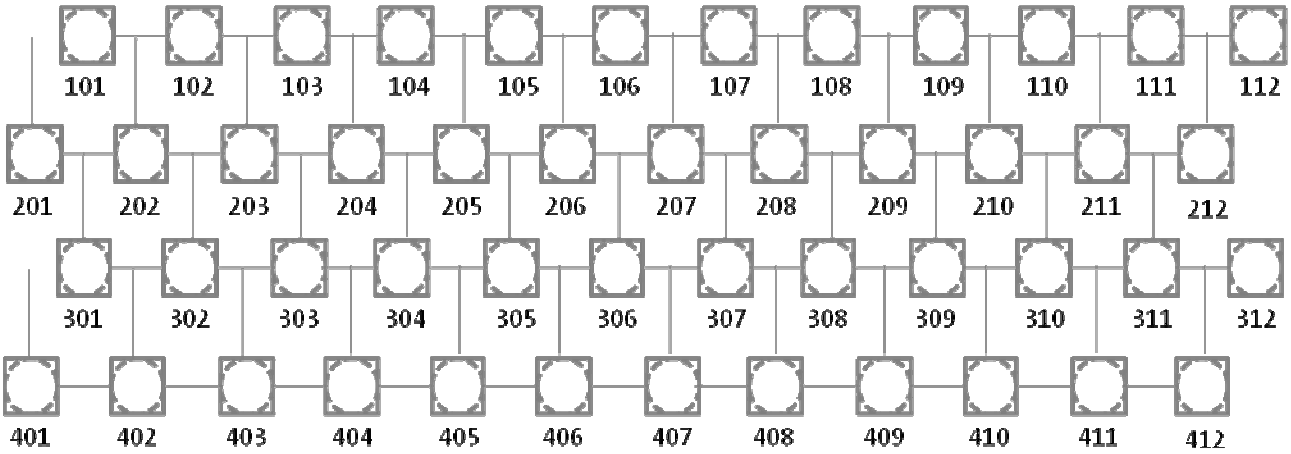
**Genetic evaluation of molecular pathologic markers for hypertrophic cardiomyopathy** ☐

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 $K_2$EDTA or $K_3$EDTA 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** _____