HEARTGENETICS
GENETICS & BIOTECHNOLOGY

MOLECULAR TEST REQUISITION FORM

GENETIC EVALUATION OF THROMBOPHILIA

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

Acronym: _____ (1st letter of each name or a number) 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 thrombophilia ☐

This test encompasses the evaluation of genetic variations that can be considered a risk factor of thrombophilia because: 1) they can result in a deficiency of natural inhibitors of coagulation or 2) they can promote an increased level of coagulation factors. Evaluation of 14 genetic variants associated with thrombophilia will be performed for the 10 following genes: *F13A*, FII, *FV, FBG*, *GP1BA*, *MTHFR*, *PAI1*, *PROCR*, *PROS1, SERPNIC1*.

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

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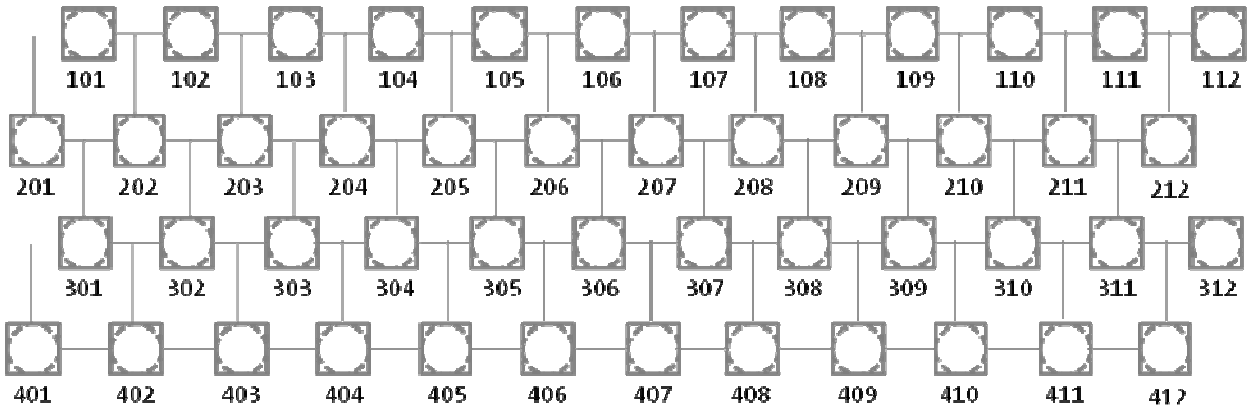
FAMILIAR INFORMATION

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



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

RELEVANT CLINICAL INFORMATION / 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

DOCUMENTS SIGNED BY PHYSICIAN

Statement of liability ☐

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 ☐

Acronym: _____ (1st letter of each name or a number)

Consultancy Referral Number**:** _____

INFORMED CONSENT INFORMATION (It is mandatory to be signed)

MY SIGNATURE ON THE INFORMED CONSENT DOCUMENT WAS PERFORMED AFTER SIGNATURE OF THE PATIENT / INDIVIDUAL. I WILL BE RESPONSIBLE FOR SAVING SUCH DOCUMENT.

Date: ____/____/_____; **Physician signature:** _____