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 EVALUATION OF THROMBOPHILIA

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: _____Departament:_____

Telephone: _____ Fax: _____ E-mail: _____

MOLECULAR TEST REQUESTED (obligatory field)

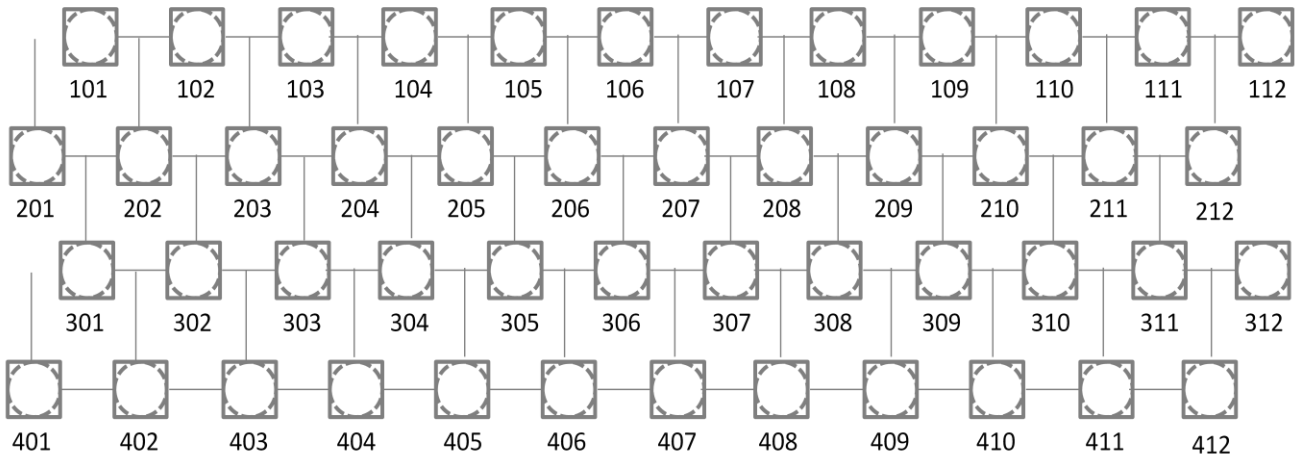
Genetic evaluation of Thrombophilia ☐

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, SERPINC1*.

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 ↗.



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 EVALUATION OF THROMBOPHILIA

Name: _____

Consultancy Referral Number: _____

Position in the tree	Name / Consultancy Referral Number	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

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 Thrombophilia 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___	_____	_____