



**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)

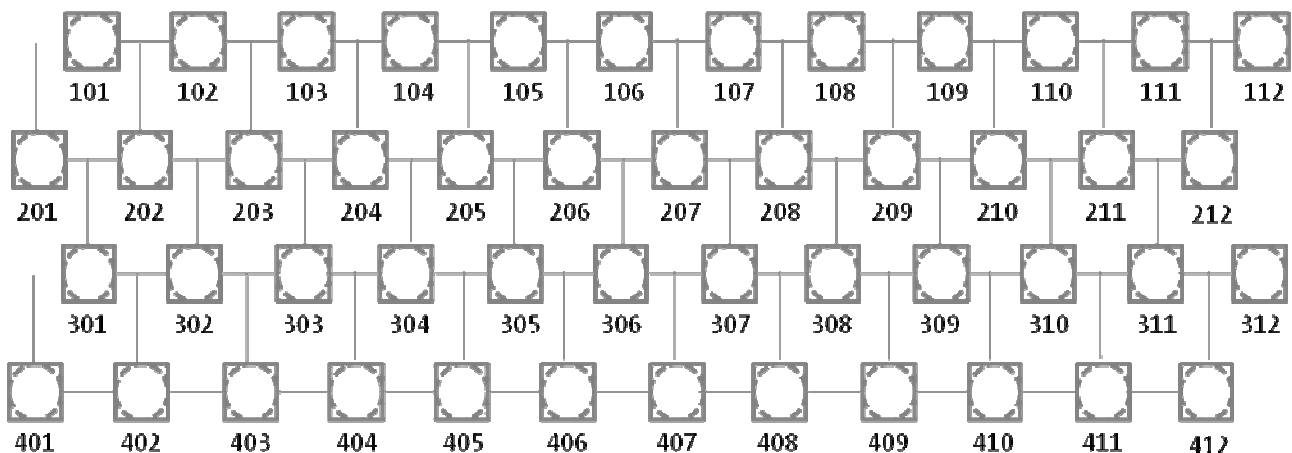
**Genetic evaluation of thrombophilia** ☐

This test encompasses the evaluation of genetic variations that can be considered a risk factor of thrombophilia for the reason that: 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: *FII*, *FV*, *F13A*, *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 ↗.





MOLECULAR TEST REQUISITION FORM  
**GENETIC EVALUATION OF THROMBOPHILIA**

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<sub>2</sub>EDTA or K<sub>3</sub>EDTA collection tube
- ☐ DNA (Date obtained: \_\_\_\_ / \_\_\_\_ / \_\_\_\_); Volume \_\_\_\_ µL; Concentration \_\_\_\_ µg/mL; Purification Method: \_\_\_\_\_; Conditions: minimum 300ng of 35ng/µL,
- ☐ Saliva (Recommended kit: 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 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** \_\_\_\_\_