HEARTGENETICS
GENETICS & BIOTECHNOLOGY

MOLECULAR TEST REQUISITION FORM

GENETIC ANALYSIS OF HYPERTROPHIC CARDIOMYOPATHY

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 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 56 genes associated with hypertrophic cardiomyopathy.

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

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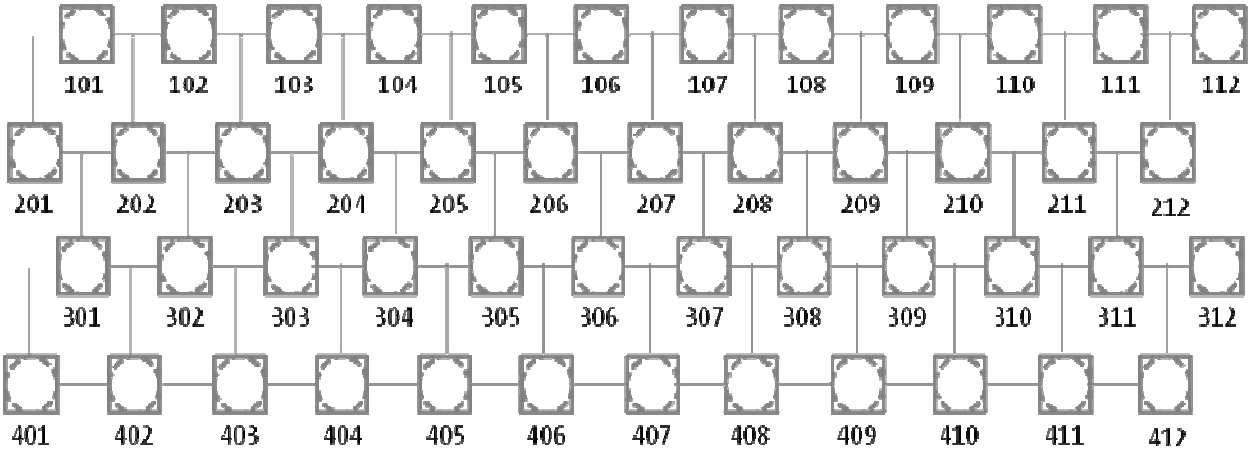
FAMILIAR INFORMATION

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

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

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:** _____