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 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: _____Departament:_____

Telephone: _____ Fax: _____ E-mail: _____

MOLECULAR TEST REQUESTED (obligatory field)

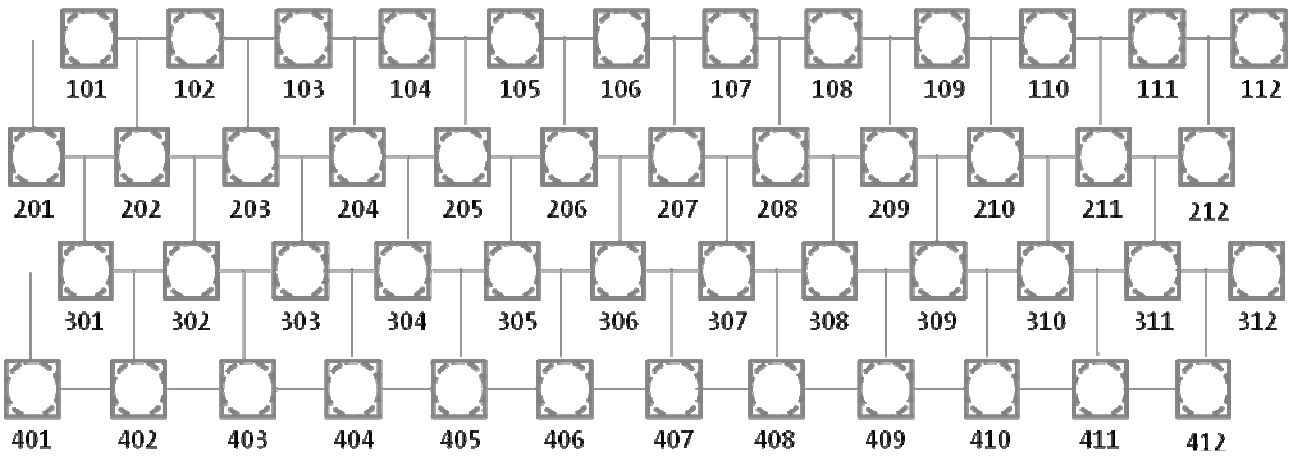
Genetic evaluation of thrombophilia ☐

This test encompasses the evaluation of genetic variations that can be considered a risk factor of thrombophilia 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 ↗.



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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_2EDTA or K_3EDTA 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 _____