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 FAMILIAL HYPERCHOLESTEROLEMIA

FULL PANEL

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)

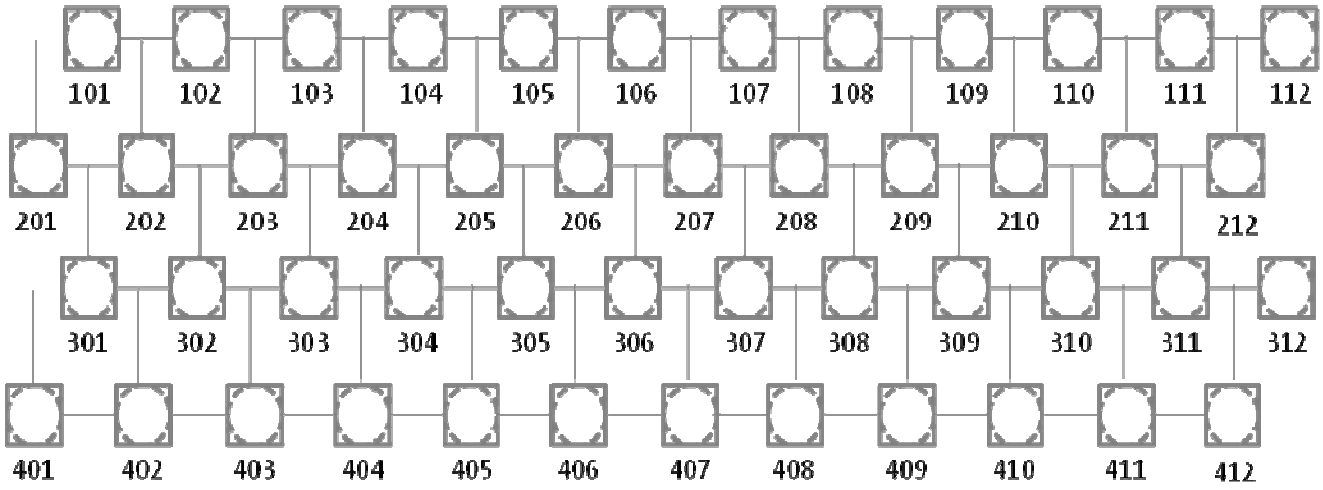
Genetic evaluation of familial hypercholesterolemia - Full panel ☐

Evaluation of genetic mutations of *LDLR, APOB and PCSK9* genes that cause familial hypercholesterolemia and that are related with high levels of total cholesterol and LDL cholesterol levels and increased risk of premature cardiovascular disease. In addition are evaluated the genetic alterations of *ApoE* gene that are associated with increased risk of premature cardiovascular disease.

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 an arrow (↗).



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FULL PANEL

Name: _____

Consultancy Referral Number: _____

Position in the tree	Name / Consultancy Referral Number	Clinical information and age of diagnostic

CLINICAL INFORMATION: COMPLEMENTARY DIAGNOSTIC EXAMS

By filling these fields you are contributing to improve your future patient diagnostics as we are developing tools to model clinical and genetic data regarding Arterial Hypertension risk factors.

Clinical Information	**Data**
Date and age of diagnostic	_____(day) / _____(month) / _____(year), _____ years
Total cholesterol _____ pv tp mg/dl, _____ af tp mg/dl; **LDL-C** _____ pv tp mg/dl, _____ af tp mg/dl; **HDL** _____ pv tp mg/dl, _____ af tp mg/dl; **VLDL** _____ pv tp mg/dl, _____ af tp mg/dl, **non-HLDL cholesterol** _____ pv tp mg/dl, _____ af tp mg/dl; **ApoA1**_____mg/dl, **ApoB** _____mg/dl (pv tp - previous therapeutics, af tp - after therapeutics)	
Personal history of cardiovascular diseases	Myocardial Infarction ☐ _____ (Y), Angina ☐ _____ (Y), STENT ☐ _____ (Y), Coronary Bypass ☐ _____ (Y), Aneurysms _____ (Y) , Carotid Artery Disease ☐ _____ (A), Stroke ☐ _____ (y) Premature peripheral arterial disease ☐ _____ (Y), Renovascular Hypertension ☐ _____ (y)
Signs	Tendon xanthomas ☐, Xanthelasmas ☐, Arcus senilis ☐, Fat liver ☐
Associated diseases	Thyroid disease ☐, Liver disease ☐, Pancreatic disease ☐, Autoimmune disease ☐, Chronic kidney disease ☐, Arterial hypertension ☐
Family history	High cholesterol ☐, High LDL ☐, Premature cardiovascular disease (before 55 in a man and before 60 in a woman) ☐, sudden death ☐
Associated risk factors	Fast food ☐, Lack of physical activity ☐, Obesity ☐, Overweight ☐, Units of alcohol (1 unit = 1 glass) / week _____ , Smoking ☐, nº cigarettes /day___, nº packs /day _____, stop smoking at ____ years____
Therapeutics	

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FULL PANEL

Name: _____

Consultancy Referral Number: _____

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 hypertrophic cardiomyopathy 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 _____