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 ANALYSIS OF HYPERTROPHIC CARDIOMYOPATHY

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)

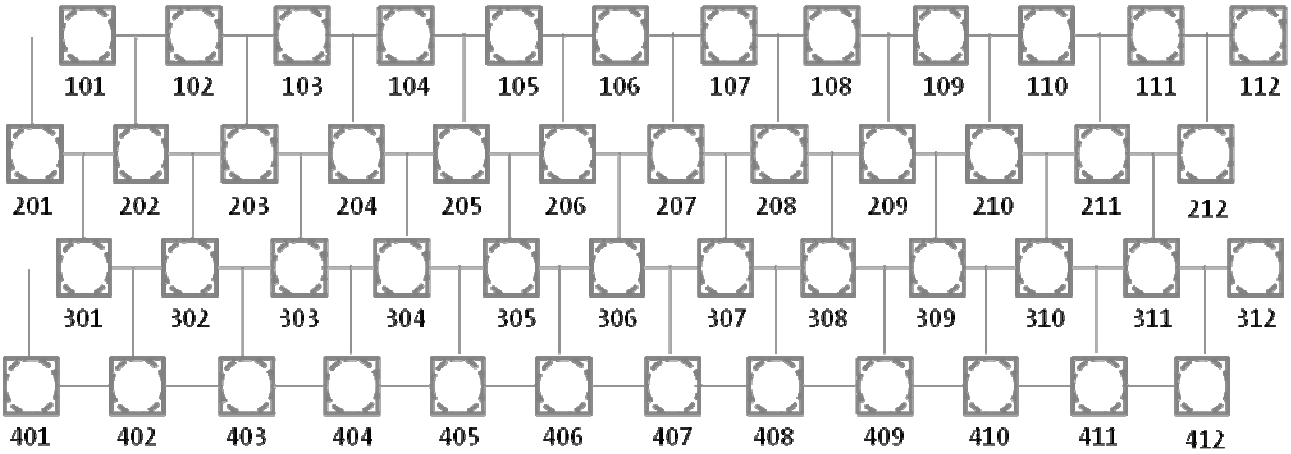
Genetic evaluation of hypertrophic cardiomyopathy ☐

Evaluation of genetic alterations in 53 genes associated with hypertrophic cardiomyopathy development, in particular the ones 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.

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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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: 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 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 _____