Complete and print.

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MAYO CLINIC LABORATORIES

Hereditary Cardiomyopathies and Arrhythmias: Patient Information

H C A P T I N

Instructions: The accurate interpretation and reporting of the genetic results is contingent upon the reason for referral, clinical information, ethnic background, and family history. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Personalized Genomics Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email mclglobal@mayo.edu**

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax*
Other Contact Name *(Last, First)*	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Is this a postmortem specimen? ☐ Yes ☐ No If yes, attach autopsy report if available.

Clinical History Attach medical records/diagnostic tests.

Reason for Testing (Check all that apply.)

☐ Diagnosis ☐ Carrier testing ☐ Presymptomatic diagnosis ☐ Family history ☐ Sudden death

Note: Genetic testing should always be initiated on an affected family member first, if possible, in order to be most informative for at-risk relatives. See Ethnic Background and Family History section for more information.

Diagnosis

Is this patient affected by one or more of the following? ☐ Yes ☐ No If yes, check all that apply.

☐ HCM ☐ DCM ☐ ARVC ☐ LVNC ☐ Other cardiomyopathy: _____

☐ CPVT ☐ Brugada ☐ Long QT ☐ Other arrhythmia: _____

☐ Other: _____

Age at diagnosis: _____

Has patient had:

Sudden cardiac arrest ☐ Yes ☐ No Describe: _____

Sudden cardiac death ☐ Yes ☐ No Describe: _____

Syncope ☐ Yes ☐ No Describe: _____

ARVC: RV fatty infiltration ☐ Yes ☐ No

Arrhythmia: Maximum QTc interval _____ msec

Conduction system disease ☐ Yes ☐ No Describe: _____

Cardiomyopathy:

LV hypertrophy ☐ Yes ☐ No Maximum LV wall thickness _____ mm

LV Dilation ☐ Yes ☐ No LV internal diameter, diastole _____ mm

Ejection fraction _____%

Other Relevant Information

T725

Patient Information (required)

Patient Name *(Last, First, Middle)*	Patient ID (Medical Record Number)

Ethnic Background and Family History

☐ European Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle Eastern ☐ Other, specify: _____

Are other relatives known to be affected? ☐ Yes ☐ No

If yes, indicate their diagnosis and relationship to the patient: _____

Have other relatives had molecular genetic testing? ☐ Yes ☐ No

For known mutation test requests, order known variant analysis:

KVAR1 / Known Variant Analysis-1 Variant, Varies

KVAR2 / Known Variant Analysis-2 Variants, Varies

KVAR3 / Known Variant Analysis-3+ Variants, Varies

New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576), Informed Consent for Genetic Testing – Spanish (T826), or Informed Consent for Genetic Testing for Deceased Individuals (T782).

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