

Hereditary Cardiomyopathies and Arrhythmias: Patient Information

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Instructions: This form is intended to be completed by the ordering healthcare professional. Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ancestry, and biological 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: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1710 / International clients: 855-379-3115 or +1-507-284-9273, or email mliintl@mayo.edu.**

Patient Information

Patient Name (Last, First Middle)		Birth Date (mm-dd-yyyy)	
Preferred Name		Medical Record Number (if Birth Date is not available)	
Sex Assigned at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other, specify:		Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary ☐ Choose not to disclose ☐ Other, specify:	
Gender Identity (optional)		Pronouns (optional)	

Referring Healthcare Professional Information

Referring Healthcare Professional Name (Last, First)	Phone	Fax*
Genetic Counselor/Other Healthcare Professional 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.

Reason for Testing Check all that apply.

☐ Diagnosis ☐ Biological family history** ☐ Sudden death
 **Genetic testing should be performed on an affected biological family member first, when possible. FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

Clinical History Attach medical records/diagnostic tests.

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 _____ %

Hereditary Cardiomyopathies and Arrhythmias: Patient Information (continued)

Patient Information (required)

Patient Name (Last, First Middle)	Birth Date (mm-dd-yyyy)
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Clinical History (continued)

Other Relevant Information

Biological Family History

Are there similarly affected biological relatives?	☐ Yes	☐ No						
If "Yes," indicate relationship and symptoms:								
Have any biological family members had genetic testing?			☐ Yes***	☐ No	☐ Unknown			
***FMTT / Familial Variant, Targeted Testing should be ordered when there is a previous positive genetic test result in the biological family. Contact the lab for ordering assistance.								
History of consanguinity								
☐ No						☐ Unknown	☐ Choose not to disclose	☐ Yes; biological relationship details:

Patient Ancestry

Patient ancestry:	☐ Unknown	☐ Choose not to disclose
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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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