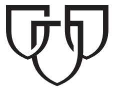

MAYO CLINIC LABORATORIES

# Hereditary Cardiomyopathies and Arrhythmias: Patient Information

**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)* | Gender ☐ 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

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## 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

KVAR2 / Known Variant Analysis-2 Variants

KVAR3 / Known Variant Analysis-3+ Variants

**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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