INSTITUT DE CARDIOLOGIE DE MONTRÉAL

Cardiovascular Genetics Test Requisition Form

Molecular Diagnostic Laboratory

Montreal Heart Institute
5000, Belanger East Street, C-1760
Montreal (Quebec) H1T 1C8
Phone : 514 376-3330 ext 3712
Fax : 514 593-2577

Last Name, First Name :
Date of Birth :
Sex :
Record number : Addressograph
RAMQ number (if available):
Contact (Phone number) :

A- Sample Information — *Required*

Date : yyyy - mm - dd
Collected by (Name) :
Laboratory reference number :
☐ **Patient's consent was obtained *(A copy of the signed consent form must be provided)***

For laboratory use

Sample type (check) :
☐ Lavender tube (EDTA) – One 4 ml tube required
☐ DNA Quantity required : 5 µg Concentration (must be indicated on tubes) :
N.B.: DNA samples extracted from Formalin-fixed, paraffin-embedded (FFPE) tissues will not be accepted.

B- Reason for this request (Please check all that apply) : — *Required*

☐ Genetics test request (Please *complete section D **or** E*)
Family number (if known) :
Patient ethnicity (ex : french canadian) :
☐ DNA banking
☐ Additional testing (Please *complete section D **or** E*)
☐ Deceased patient Date of death:

C- Clinical information (Please check all that apply) : — *Required*

Inherited cardiovascular condition (known or suspected)

☐ Hypertrophic cardiomyopathy
☐ Dilated cardiomyopathy
☐ Arrhythmogenic right ventricular cardiomyopathy
☐ Left ventricular non-compaction cardiomyopathy
☐ Andersen-Tawil syndrome
☐ Brugada syndrome
☐ Long QT syndrome
☐ Amyloidosis
☐ Short QT syndrome
☐ Catecholaminergic polymorphic ventricular tachycardia
☐ Unexplained sudden cardiac death
☐ Familial progressive cardiac conduction defect
☐ Familial thoracic aortic aneurysm and dissection
☐ Ehlers-Danlos syndrome
☐ Loeys-Dietz syndrome
☐ Marfan syndrome
☐ Other :

D- Patient's phenotype — *Required*

Clinical data:
☐ Summary letter (diagnostic)
☐ Examination report(s)
☐ Other :

Familial History :

E- Targeted variant(s) testing only — *Required for family member*

Specific Variant(s) :

For variant(s) not reported by our laboratory, please attach a copy of a family member's report if available.

Gene(s)	Transcript	Nucleic Change	Protein Change

F- Cardiac Panel Test (Please check all that apply)

Required for proband

Please note that sequential analyzes are performed. If no clinically significant variant is identified within the first-line analysis, the second and third-line panels will automatically be completed.

	Genes		
Inherited cardiomyopathies	**First-Line**	**Second-Line**	**Third-Line**
☐ Hypertrophic cardiomyopathy	*GLA, LAMP2, MYBPC3, MYH7, PRKAG2, TNNI3, TNNT2, TPM1*	*ACTC1, ACTN2, ANKRD1, CAV3, CSRP3, JPH2, MYH6, MYL2, MYL3, MYOZ2, NEXN, PLN, PTPN11, RAF1, TCAP, TNNC1, TTR*	-
☐ Dilated cardiomyopathy and left ventricular non-compaction cardiomyopathy	*BAG3, LDB3, LMNA, MYBPC3, MYH6, MYH7, MYPN, RBM20, SCN5A, TNNI3, TNNT2, TTN*	*ABCC9, ACTC1, ACTN2, ANKDR1, CSRP3, DES, DMD, DSC2, DSG2, DSP, EMD, JUP, LAMP2, NEXN, PKP2, PLN, RAF1, SGCD, TAZ, TCAP, TNNC1, TPM1, VCL*	-
☐ Arrhythmogenic right ventricular cardiomyopathy	*DSC2, DSG2, DSP, JUP, PKP2, TMEM43*	*DES, LMNA, PLN, RYR2, SCN5A, TGFB3, TTN*	-
☐ Amyloidosis	*TTR*	-	-
☐ Pan cardiomyopathy panel	Include all the genes from the inherited cardiomyopathies section		
Inherited arrhythmias			
☐ Andersen-Tawil syndrome	*KCNJ2*	-	-
☐ Brugada syndrome	*SCN5A*	-	-
☐ Long QT syndrome	*KCNE1, KCNE2, KCNH2, KCNQ1, SCN5A*	*AKAP9, ANK2, CACNA1C, CALM1,CALM2, CAV3, KCNJ2, KCNJ5, SCN4B, SNTA1*	-
☐ Short QT syndrome	*KCNH2, KCNJ2, KCNQ1*	*CACNA1C, CACNA2D1, CACNB2*	-
☐ Catecholaminergic polymorphic ventricular tachycardia	*CASQ2, KCNJ2, RYR2*	*ANK2, CALM1, CALM2, TRDN*	-
☐ Unexplained sudden cardiac death	*KCNH2, KCNQ1, RYR2, SCN5A*	-	-
☐ Familial progressive cardiac conduction defect	*DES, HCN4, LMNA, PRKAG2, TRPM4, SCN1B, SCN5A*	*NKX2-5, TBX5, TNNI3K*	-
☐ Pan arrhythmia panel	Include all the genes from the Inherited arrhythmias section		
Inherited aortopathies			
☐ Familial thoracic aortic aneurysm and dissection	*ACTA2*	*FBN1, SMAD3, TGFB2, TGFB3, TGFBR1, TGFBR2*	*MYH11, MYLK, SLC2A10*
☐ Ehlers-Danlos type I syndrome	*COL5A1, COL5A2*	-	-
☐ Ehlers-Danlos type IV syndrome	*COL3A1*	-	-
☐ Loeys-Dietz syndrome	*SMAD3, TGFB2, TGFB3, TGFBR1, TGFBR2*	-	-
☐ Marfan syndrome	*FBN1*	-	-

Additionnal gene(s) :

G- Health Care Professional Information :

Required

☐ **I confirm that this test is medically indicated for the stated clinical condition and that the results will be used for clinical purposes for the patient. I have explained to the patient or his / her representative / legal guardian the indicated genetic analysis and its objectives, limitations, risks and benefits and have satisfactorily answered all related questions.**

Last Name & First Name : _____ License number : _____
Full address : _____ Phone : _____
_____ Fax : _____
_____ Date : _____
Signature : _____

☐ c.c. Additional reporting provider, coroner, genetic counselor or other:

Last Name & First Name : _____ License number : _____
Full address : _____ Phone : _____
_____ Fax : _____

H- Laboratory Contact Information :

Institution : _____ Contact person : _____
Full address : _____ Phone : _____
_____ Fax : _____