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MAYO CLINIC LABORATORIES

Hereditary Cardiomyopathies and Arrhythmias: Patient Information

H C A P T I N

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, 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: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 507-266-5700 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

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.

Reason for Testing Check all that apply.

☐ Diagnosis ☐ Family history** ☐ Sudden death

** Genetic testing should be performed on an affected family member first, when possible. FMTT / Familial Mutation 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 %

Other Relevant Information

T725
MC1235-207rev0123

Patient Information (required)

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

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any family member had genetic testing? ☐ Yes*** ☐ No ☐ Unknown

*****FMTT / Familial Mutation Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.**

History of consanguinity: ☐ No ☐ Yes; relationship details:

Ancestry

☐ African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Choose not to disclose
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Unknown

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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