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Order form
Genetic characterisation of cardiomyopathies and arrhythmia syndromes

HCL HOSPICES CIVILS DE LYON

INTERNATIONAL DIVISION
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Invoicing	Client no.
☑ Laboratory	

REFERRING PHYSICIAN

Last name: .....
First name: .....
Address: .....
Postal code: ⌊⌊⌊⌊⌊⌋ City: .....
Country: .....
Email: .....
Tel.: ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊
Fax: ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊

Stamp of prescriber

PATIENT

Last name: .....
First name: .....
Name at birth: .....
Date of birth: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊
Gender: ☐ F ☐ M

Sample collection date: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊
Type of sample: .....

INDEX CASE: ANALYSES AND CLINICAL DETAILS

CARDIOMYOPATHIES

ANALYSES

Hypertrophic cardiomyopathy (HCM)

☐ Analysis of major genes* - ***1st line panel***

☐ Analysis of the entire "Cardiomyopathies" gene panel* - ***2nd line panel***
(After confirmation of the proposed diagnosis and phenotypic details necessary for interpretation)

Dilated cardiomyopathy (DCM)

☐ Analysis of the entire "Cardiomyopathies" gene panel*

Restrictive cardiomyopathy (RCM)

☐ Analysis of the entire "Cardiomyopathies" gene panel*

Left ventricular Non Compaction (LVNC)

☐ Analysis of the entire "Cardiomyopathies" gene panel*

☐ **Arrhythmogenic right ventricular dysplasia (ARVD)***

** List of analysed genes available on request*

CLINICAL DETAILS

First symptom(s)

Age of onset: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊
Age of diagnosis: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

Clinical signs: ☐ YES ☐ NO
☐ Dyspnoea ☐ Chest pains ☐ Nausea
☐ Syncopes ☐ Death
Other cases in family *(specify)* : .....

Tests performed:
☐ ECG ☐ Ultrasound ☐ MRI ☐ Exercise test

Cardiomyopathy type

☐ Hypertrophic
Septum: .....mm Posterior wall: .....mm
☐ Dilated LEVF: .....
☐ Restrictive
☐ LV Non Compaction

Arrhythmia syndromes

☐ AV conduction disorders
☐ AV block: .....
☐ Short PR
☐ WPW
☐ Other: .....

Arrhythmogenic right ventricular dysplasia

Abnormality of the right ventricle on cardiac ultrasound, angiography, MRI ☐ YES ☐ NO
Abnormality on ECG; Negative T waves in V2, V3 ☐ YES ☐ NO
Presence of epsilon wave ☐ YES ☐ NO
Other information: .....

Associated signs

CK level: .....
☐ Myopathic disease
☐ Mental retardation

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ARRYTHMIAS

ANALYSES

- ☐ Congenital Long QT syndrome (LQTS)*
- ☐ Brugada syndrome (BrS)*
- ☐ Short QT syndrome (SQTS)*
- ☐ Jervell Lange-Nielsen syndrome (JLNS)*
- ☐ Andersen-Tawil syndrome (ATS)*
- ☐ Timothy syndrome (TS)*
- ☐ Cardiac Conduction Disorder (CCD)*
- ☐ Catecholaminergic polymorphic ventricular tachycardia (CPVT)*
- ☐ Analysis of the whole panel of "cardiac arrhythmia" genes (ArC)**

(After confirmation of the proposed diagnosis and phenotypic details necessary for interpretation)

** List of analysed genes available on request*

CLINICAL DETAILS

Long QT or Short QT syndrome

QTc value: .....

Syncopes: ☐ YES ☐ NO

Death: ☐ YES ☐ NO

Exercise ECG test: ☐ YES ☐ NO

Results: .....

Other information: .....

Brugada syndrome

Resting ECG:

ST elevation >2 mm: ☐ YES ☐ NO

Right bundle branch block: ☐ YES ☐ NO

Cardiac ultrasound or other abnormalities: ☐ YES ☐ NO

Ajmaline test: ☐ Positive (elevation > 2mm) ☐ Negative

Other information: .....

Other rhythmic pathologies *(specify)* **:**

.....

.....

.....

SUDDEN CARDIAC DEATH

ANALYSES

- ☐ NGS Panel Sequencing Sudden Cardiac Death (MSC)*

** List of analysed genes available on request*

CLINICAL DETAILS

Specify : .....

.....

.....

.....

.....

.....

OPTIONAL ANALYSIS

ANALYSIS

- ☐ Pharmacogenetic profile

TREATMENTS RELATED TO THE REQUEST

Past treatments: .....

.....

Current treatments: .....

.....

Planned treatments: .....

.....

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FAMILY TREE

Geographical origin*: .....

*(*The frequency and distribution of genetic mutations differs according to the ethnic/geographical origins of the patient)*

Consanguinity: ☐ YES *(please indicate on the family tree)* ☐ NO

IMPORTANT:
SCREENING OF A RELATIVE IS ONLY POSSIBLE IF THE ANALYSIS OF THE INDEX CASE HAS BEEN ENTRUSTED TO OUR LABORATORY.

DIRECT SCREENING FOR VARIATION(S) OF A RELATIVE

☐ **Symptomatic** ☐ **Non symptomatic** ☐ **1st sample** ☐ **2nd sample**

Gene:..... Variation: ..... (or photocopy of previous result)

Gene: ..... Variation: ..... (or photocopy of previous result)

Relevant

Last name: ..... First name: .....

Date of birth: ☐☐/☐☐/☐☐☐☐ Gender: ☐ F ☐ M

Family relationship with the index case: .....

Sample collection date: ..... Type of sample: .....

☐ Sample included with index case sample

☐ Sample not taken from blood relative / Sample not sent alongside index case sample

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Declaration of genetic consultation and informed consent

INTERNATIONAL DIVISION
Tel: 04 72 80 23 85 • Fax: 04 72 80 73 56 • Email: international@biomnis.eurofinseu.com

CONSENT FOR THE GENETIC CHARACTERISTICS TEST ON AN INDIVIDUAL AND THE PRESERVATION OF SAMPLES

Patient information Last name: .....First name: .....
Date of birth: |__|__| |__|__| |__|__|__|__|

Legal representative(s) information *(as appropriate)* Last name: .....First name: .....
(as appropriate) Last name: .....First name: .....

I, the undersigned, declare that I have been informed by:

☐ Dr .....

☐ Genetic Counsellor ..... under the responsibility of Dr .....
and on their behalf

about the genetic characteristics test which will conducted on a sample/samples taken from:

☐ Myself
☐ My child or an adult under my guardianship

For: *(mandatory statement of the name of the pathology or name of the test conducted according to an aetiological, predictive or healthy carrier diagnosis)*

.....

ACKNOWLEDGEMENT OF THE FOLLOWING INFORMATION:

I declare that I have received the information needed to understand this test and its purpose.
I consent to this test being performed.

The results of the test will be provided to me and explained based on the current state of knowledge by the doctor/genetic counsellor who prescribed it as part of an individual consultation. The doctor/genetic counsellor will explain the necessary treatment methods where appropriate.

I understand that if a genetic abnormality that could be responsible for a predisposition or a serious affliction is identified, I must allow this information to be passed on to the rest of my/their family. I have been warned that remaining silent could pose a risk to them and their descendants, where preventive measures, including genetic counselling or treatment, could be proposed. I can either share this genetic information with members of my/their family myself, or permit the prescribing physician to do so.

I authorise, in compliance with medical confidentiality: The transmission of information from my/their medical file to the doctors involved with this test.

I acknowledge that my/the personal data relevant for making a diagnosis and the results report for my/their test will be kept, in paper form or in a digital database, by the prescribing physician and the medical biology laboratory authorised to conduct this test, in accordance with the regulations in force.

I have been informed that, in accordance with the current laws, my/their sample will be destroyed once the legal retention period has expired or, unless requested otherwise by myself in writing sent to the Eurofins Biomnis administrative office, used and transferred, anonymously and according to medical confidentiality, for scientific or quality control purposes.

In addition, cross out any of the following paragraphs that you disagree with:

* I wish to be informed of the results of the test conducted.
* Genetic information not directly linked to my/their pathology but which may have an impact on my/their care and/or treatment or that of my/their relatives may be disclosed. I wish for this information to be disclosed to me:
  ☐ YES ☐ NO ☐ Not applicable
* I agree for the transmission and use of my/their results for the genetic analysis of other members of my family who may wish for a consultation.
* I agree for a sample of a biological material from me/them to be kept and used at a later date to continue the investigation as part of this diagnostic approach, according to developments in medical knowledge.

Signed in..... ,
On |__|__| |__|__| |__|__|

Signature of the patient or legal representative(s) for a minor or adult under guardianship

REFERRING PHYSICIAN DECLARATION OF CONSULTATION**

I certify that I have informed the patient named above or their legal representative of the characteristics of the disease being tested for, the means for identifying it, the reliability of the analyses, options for prevention and treatment and how the disease in question can be transmitted genetically, along with its potential consequences for other members of the family.
I certify that I have received the consent of the patient named above or their legal representative according to the conditions laid down in the regulations in force.

Signed in ..... on .....

Signature and stamp

***REMINDER OF THE REGULATIONS**

***The referring physician** must keep:*

- *The written consent*
- *Duplicates of the prescription and declaration*
- *The reports of medical biology analyses with discussion and which have been signed (Art. R1131-5).*

***The authorised laboratory** conducting the tests must:*

- *Ensure that there is a prescription, referring physician declaration and written consent from the patient*
- *Send, to the referring physician, who alone is authorised to communicate the results to the individual concerned, the medical biology analysis report with discussion and which is signed by an approved practitioner*
- *Send, where appropriate, to the laboratory that transmitted the sample and was involved in the analysis, the medical biology analysis report with discussion and which is signed by an approved practitioner*

Law no. 2011-814 of 7 July 2011 *on bioethics*

Order of 27 May 2013 *defining the rules of good practice applicable to the genetic characteristics test on an individual for medical purposes*

Decree no. 2013-527 of 20 June 2013 *on the conditions for informing biological relative in relation to genetic characteristics tests for medical purposes*

Decree no. 2008-321 of 4 April 2008 *on genetic characteristics tests on an individual or their identification via genetic fingerprinting for medical purposes.*

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