CARDIAC AND AORTIC PANELS KNOW&MANAGE

BARCODE

PHYSICIAN INFORMATION

INSTITUTION/PRACTICE	ADDRESS (STREET NAME, NO., CITY, POSTAL CODE, COUNTRY)
FIRST NAME	TELEPHONE NUMBER (COUNTRY CODE & NUMBER)
LAST NAME	E-MAIL ADDRESS (FOR REPORT ACCESS)

PATIENT INFORMATION

FIRST NAME	ADDRESS (STREET NAME, NO., CITY, POSTCODE, COUNTRY)
LAST NAME	TELEPHONE NUMBER (COUNTRY CODE & NUMBER)
DATE OF BIRTH (DD/MM/YYYY)	GENDER (MALE/FEMALE/OTHER - SPECIFY KARYOTYPE)
PERSONAL IDENTIFICATION NO.	SAMPLE COLLECTION DATE (DD/MM/YYYY)

REASON FOR TEST (DIAGNOSIS, PREDICTIVE, CARRIER)

DECLARATION OF CONSENT (ACCORDING TO GERMAN GENETIC DIAGNOSTICS ACT, GenDG)

Applicable only for the determination of genetic (hereditary) characteristics

The GenDG requires provision of detailed information and a written consent for all genetic investigations as well as genetic counselling prior to both predictive (applies to healthy individuals) and prenatal testing (with restrictions: prenatal testing is not performed for late manifesting disorders, including Hereditary Cancer Panels). The German Society of Human Genetics (GfH) and the Association of German Human Geneticists (BVDH) recommend clarifying the issues listed below during the information process. Please read the declaration of consent carefully and tick the boxes, in accordance with your consent.

By signing the form below I confirm that I:

- Have been fully informed by my physician about the significance and consequences of the genetic investigation, in compliance with GenDG.
- Have read/have been read the Information for Patients (page 5) which is attached to this form and which I fully understand.
- Have been given sufficient opportunity to discuss open questions.
- Authorize [insert legal entity here] to collect the necessary samples for investigation (blood, tissue, chorionic villus cells or amniotic fluid for prenatal diagnosis) and to send this form to MVZ Martinsried GmbH, Lochhamer Str. 29, 82152 Martinsried, Germany, in order to perform the tests requested through this form.
- Consent to the genetic test being carried out in order to clarify the disease/dysfunction/suspected diagnosis.

YES	NO	
☐	☐	I agree that the investigation or parts of the investigation may be forwarded to collaborating medical laboratories, if necessary.
☐	☐	I agree with the evaluation of additional genes in the same indication group as part of the research.
☐	☐	I agree that the remaining specimens may be stored for further investigations after the examination is completed, yet not claiming storage.
☐	☐	I agree that the specimens, and if applicable DNA sequence information, may be made available anonymously for quality management and scientific purposes.
☐	☐	I agree that the results of the analysis may be stored for a longer period than the statutory period of 10 years, yet not claiming storage of results.
☐	☐	I agree to the storage and use of my test results under the protection of anonymity in a statistical database used for scientific purposes and to help diagnose genetic diseases. I understand that I will remain under the protection of anonymity and I cannot be identified during the analysis of the data and that any personal information will be transformed into information of a non-personal nature.

By signing the form below I confirm that:

- I may stop the investigation at any time and ask for the results available until that time to be destroyed.
- I may withdraw any of my consents given through this form entirely or in part at any time without giving reasons.
- I will be charged for the costs incurred until the time of withdrawal of consent.
- I may choose not to be informed about the test results (right not to know).
- I know that the genetic investigation and evaluation is limited to the requested indication and no statements will be made about other diseases.
- All information I have provided is true and correct.

Communication of additional findings found during the course of the research

☐ YES, I wish to be informed about additional findings.
☐ NO, I do not wish to be informed about additional findings.

In addition,

- YES☐ NO☐ I agree that a copy of the results of the analysis may be sent to the following physician(s), in accordance with my express requests and according to [insert legal entity here] internal procedures.

DR(S) NAME

STREET

POSTCODE/CITY

COUNTRY

PLACE

DATE

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN

PHYSICIAN'S SIGNATURE

MEDICOVER GENETICS
MVZ Martinsried GmbH
Lochhamer Str.29, 82152 Martinsried, Germany
Accreditation: DIN EN ISO 15189
www.medicover-genetics.com

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Address: xxxxxxxxxxxxxxxxxxxxxxxxxx
E-mail: xxxxxxxxxxxxxxxxxxxxxxxxxxxx
Website: xxxxxxxxxxxxxxxxxxxxxxxxxx

Insert your logo here

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PATIENT INFORMATION

Indication: _____

Is there a pregnancy / partner's pregnancy? ☐ No ☐ Yes Gestational week _____ + _____

Parental consanguinity: ☐ No ☐ Yes

CLINICAL SYMPTOMS

Family history

Are there other affected family members with similar symptoms? ☐ No ☐ Yes

If yes, who? _____

CARDIAC SYMPTOMS

- ☐ Syncope
- ☐ Hypertrophic cardiomyopathy
- ☐ Ventricular septal hypertrophy: _____ mm
- ☐ Left ventricular hypertrophy: _____ mm
- ☐ Sudden cardiac death / cardiac arrest
- ☐ Dilated cardiomyopathy
- ☐ Left ventricular dilation
- ☐ Right ventricular dilation
- ☐ Structural abnormalities of the myocardium: _____
- ☐ Left ventricular noncompaction cardiomyopathy
- ☐ Reduced left ventricular ejection fraction: _____ %
- ☐ Reduced right ventricular ejection fraction: _____ %
- ☐ Atrial septal defect
- ☐ Ventricular septal defect
- ☐ Tetralogy of Fallot
- ☐ Hypoplastic left heart syndrome
- ☐ Aortic stenosis
- ☐ Pulmonary stenosis
- ☐ Atrioventricular septal defect
- ☐ Valve defect (specify: _____)

ECG FINDINGS

- ☐ Prolonged QTc interval: _____ ms
- ☐ Torsades de Pointes
- ☐ Stress-induced polymorphic ventricular tachycardia
- ☐ Brugada Type 1 ECG
- ☐ J wave
- ☐ Epsilon wave
- ☐ ST-segment elevation
- ☐ T-wave inversion
- ☐ Delta wave
- ☐ Ventricular tachycardia
- ☐ Ventricular extrasystoles
- ☐ Atrial fibrillation
- ☐ Ventricular fibrillation
- ☐ Atrioventricular block
- ☐ Right bundle branch block
- ☐ Left bundle branch block

LABORATORY PARAMETERS *(please attach corresponding abnormal lab findings)*

- ☐ Total Cholesterol: _____
- ☐ Triglycerides: _____
- ☐ HDL-Cholesterol: _____
- ☐ Abnormal enzyme level: _____
- ☐ LDL-Cholesterol: _____

OTHER ABNORMALITIES

- ☐ Sensorineural hearing loss
- ☐ Diabetes mellitus
- ☐ Periodic paralysis
- ☐ Smoker
- ☐ Systolic blood pressure: _____
- ☐ Other abnormalities: _____

INHERITANCE - INDICATIONS OF:

- ☐ Autosomal dominant
- ☐ Autosomal recessive
- ☐ X-linked

INVESTIGATION ORDER

Our expert team is available for questions at any time: info@medicover-diagnostics.de or call +49 89 895578-0

☐ Diagnostic ☐ Predictive ☐ Prenatal

Targeted diagnostics for a known familial variant? ☐ Yes, please include a copy of the findings; alternatively, specify gene, variant, and transcript exactly:

Gene: _____ Variant: _____ Transcript: _____

For ordering whole exome sequencing, please use the Whole Exome Sequencing Decode&Discover order form.

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BARCODE

OUR PANELS

ARRHYTHMOGENIC HEART DISORDERS

- [ ] Comprehensive arrythmias & cardiomyopathies panel

ARRHYTHMIA (CHANNELOPATHIES)

- [ ] Comprehensive arrhythmias panel
- [ ] Atrial fibrillation panel
- [ ] Brugada syndrome panel
- [ ] Catecholaminergic polymorphic ventricular tachycardia panel
- [ ] Early repolarization syndrome panel
- [ ] Long QT syndrome panel
- [ ] Progressive cardiac conduction disorder panel
- [ ] Short QT syndrome panel
- [ ] Sinus node dysfunction panel

CARDIOMYOPATHIES

- [ ] Comprehensive cardiomyopathies panel
- [ ] Arrhythmogenic cardiomyopathy panel
- [ ] Dilated cardiomyopathy panel
- [ ] Hypertrophic cardiomyopathy panel
- [ ] Noncompaction cardiomyopathy panel
- [ ] Restrictive cardiomyopathy panel

SYNDROMIC FORMS OF HCM WITH EXTRACARDIAC MANIFESTATION

- [ ] Amyloidosis
- [ ] Endocardial fibroelastosis panel
- [ ] Friedreich's ataxia
- [ ] Hemochromatosis panel
- [ ] Cardiofaciocutaneous syndrome panel
- [ ] Laing syndrome panel
- [ ] Lysosomal storage disorders panel
- [ ] Mitochondrial syndromes (Leigh syndrome, MELAS, MERRF)
- [ ] Myofibrillar myopathy panel
- [ ] PRKAG2 cardiomyopathy
- [ ] RASopathies panel

AORTIC DISORDERS

- [ ] Comprehensive aortic disorders panel
- [ ] Ehlers Danlos syndrome panel
- [ ] Loeys Dietz syndrome panel
- [ ] Marfan syndrome panel
- [ ] Thoracic aortic aneurysm (+/- dissection) panel

CONGENITAL HEART DEFECTS

- [ ] Comprehensive congenital heart defects panel
- [ ] Alagille syndrome panel
- [ ] DiGeorge syndrome
- [ ] Heterotaxy panel
- [ ] Isolated & syndromic congenital heart defects panel
- [ ] RASopathies panel
- [ ] Williams Beuren syndrome

LIPID METABOLISM DISORDERS

- [ ] Familial hypercholesterolemia panel
- [ ] Hyperlipidemia / Hyperlipoproteinemia panel
- [ ] Hypolipidemia / Hypolipoproteinemia panel

PHARMACOGENETICS

- [ ] ß-blocker (*CYP2D6*)
- [ ] Clopidogrel (*CYP2C19*)
- [ ] Mavacamten (*CYP2C19*)
- [ ] Statine (*SLCO1B1*)
- [ ] Sartane (*CYP2C9*)

To request whole exome sequencing, please use the Whole Exome Sequencing Decode&Discover order form.
Please find the up-to-date list of genes for each panel on www.medicover-genetics.com.

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INFORMATION FOR PATIENTS

BARCODE

PATIENT INFORMATION

FIRST NAME	GENDER (MALE/FEMALE/OTHER - SPECIFY KARYOTYPE)
LAST NAME	TELEPHONE NUMBER (COUNTRY CODE & NUMBER)
DATE OF BIRTH (DD/MM/YYYY)	E-MAIL ADDRESS
CLINICAL DIAGNOSIS	

Genetic counselling or counselling by the ordering physician is necessary before ordering a test in order to inform the patient of all of the possible outcomes and the limitations of the genetic test.

I understand that I will be tested for:
(to be filled in by physician)

I understand that the biological sample will be used to determine if I, or members of my family, are carriers of a genetic variant causing the disease, or are carriers of the disease, or have an increased risk of developing a disease.

The role of genetic testing. In many cases, a genetic test can directly detect a genetic alteration. Molecular tests can identify structural changes in the DNA (variants). Cytogenetic tests identify the chromosomal changes (structural or numerical). The sensitivity and specificity of each test varies. The tests offered are complex analyses and are performed using high-end equipment. The methods are externally validated, but there is a minimal possibility of errors.

The significance of the results. If the result is identified as being directly causative of the clinical manifestations, it is considered to be conclusive. If the test does not identify the causative mutations of the clinical manifestations, it is considered to be inconclusive and this does not preclude other genetic changes (or non-genetic factors) responsible for the disease (a genetic disease or susceptibility to a genetic condition is not excluded). Therefore, an inconclusive result (no causative mutation identified) does not exclude the existence of other pathogenic genetic changes (variants) not tested through the current analysis.
Interpretation of the genetic results relies on a complete clinical picture of the patient, including clinical manifestations, family medical history and previous diagnoses. An error in diagnosis could occur due to a clinical picture that is different from that declared. In addition, the test can identify a possible nonpaternity. The test results will be forwarded to the patient by the geneticist or ordering physician and are confidential.

Incidental findings. Genetic testing can provide information unrelated to the purpose of the test, but that may have medical importance for the patient or family (information correlated with an increased risk for incurable disorders).

Use of the sample/result. The sample provided will be used solely for the purpose of the test and for which I have given my written consent.
Test results can also be used for research and to improve the diagnosis and treatment of genetic diseases.

The genetic material can be used for other purposes only with my prior express written consent.

Post-testing genetic counselling. A conclusive result may offer the patient information on the susceptibility, diagnosis, possible prognosis and/or heritability of the disease. An inconclusive result may lead to confusion and anxiety or may suggest the need for further genetic testing. Therefore, post-testing genetic counselling is advised for the clinical interpretation of the results.

By my signature, I hereby certify that:

1. I have been informed of the nature and purpose of the genetic test.
2. I have been informed of the benefits and limitations of the genetic test by _____ (name of physician).
3. I have been informed that the genetic test can provide information/results which have no connection with the purpose of testing. I understand that only I decide if I want those additional results to be provided.
4. I have received clear answers to my questions in relation to the genetic test.
5. I have received a copy of this form.
6. I agree to provide a sample for the above mentioned genetic test.

Completed by: ☐ Parent/Legal Guardian ☐ Patient

FIRST NAME

LAST NAME

DATE OF COMPLETION

SIGNATURE

I have explained the risks and benefits of the test as well as alternative test methods to the parent/legal guardian. I have answered all the questions from the parent/legal guardian.

Name of the ordering physician

FIRST NAME

LAST NAME

SIGNATURE OF THE ORDERING PHYSICIAN

DATE OF SIGNATURE

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