ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform cardiology genetic testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR CARDIOLOGY GENETIC TESTING

Patient Name _____ Date of Birth_____ /_____/_____ Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

Genetic Counselor _____ Counselor Phone (_____)_____

Patient's Ethnicity (check all that apply)

[ ] African-American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other_____

Suspected Diagnosis: _____ Age at Diagnosis: _____ years

SYMPTOMS? [ ] No [ ] Yes, check all that apply

[ ] Syncope, # of episodes: _____ [ ] Cardiac arrest/Sudden cardiac death [ ] Other _____

TESTS PERFORMED (check all that apply)

Electrocardiogram (ECG) [ ] Yes; maximum QTc interval ____ msec [ ] No [ ] Unknown
Echocardiogram (ECHO) [ ] Yes; maximum LV wall thickness ____ mm EF% ____ [ ] No [ ] Unknown
Left ventricular internal diastolic dimension: ____mm
Cardiac MRI [ ] Yes; maximum LV wall thickness ____ mm EF% ____ [ ] No [ ] Unknown
Left ventricular internal diastolic dimension: ____mm
RV fatty infiltrate [ ] Yes [ ] No [ ] Unknown
Other _____

Has the patient undergone previous DNA testing? [ ] No [ ] Yes [ ] Unknown
If yes, please describe the gene/disorder, methodology, and results_____

Is there an affected FAMILY MEMBER? [ ] No [ ] Yes [ ] Unknown
If yes, attach a PEDIGREE or specify the RELATIONSHIP of the relative(s) to the patient. List symptoms & age of onset
_____

Has DNA testing been performed for these family member(s)? [ ] No [ ] Yes [ ] Unknown
If YES, a copy of the relative's DNA laboratory result is <u>REQUIRED for familial mutation testing.</u>
Gene: _____ Mutation: _____

Proband's name: _____ Proband's relationship to this patient: _____

<u>Circle the test you intend to order.</u>

2006216 Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) Panel, 7 Genes
Next generation sequencing of 7 genes associated with ARVC. Clinical sensitivity is ~ 42%.
2006218 Brugada Syndrome (BrS) Panel, 7 Genes
Next generation sequencing of 7 genes associated with BrS. Clinical sensitivity is ~ 26-41%.
2006224 Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) Panel, 3 Genes
Next generation sequencing of 3 genes associated with CPVT. Clinical sensitivity is ~ 51%.
2006226 Dilated Cariomyopathy (DCM)/Left Ventricular Noncompaction (LVNC) Panel, 27 Genes
Next generation sequencing of 27 genes associated with DCM and LVNC. Clinical sensitivity is ~ 20%.
2006232 Long QT Syndrome (LQTS) Panel, 12 Genes
Next generation sequencing of 12 genes associated with LQTS. Clinical sensitivity is ~ 70%.
2006242 Short QT Syndrome (SQTS) Panel, 3 Genes
Next generation sequencing of 3 genes associated with SQTS. Clinical sensitivity is ~ 26-41%.
0097101 Known Familial Mutation Gene:_____ Mutation:_____

For questions, contact a genetic counselor at (800) 242-2787, ext. 2141

Master Label

ARUP LABORATORIES

500 Chipeta Way, Salt Lake City, Utah 84108-1221
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Web site: www.aruplab.com

INFORMED CONSENT FOR MOLECULAR GENETIC SENDOUT TESTING

Patient Name _____**Date of Birth** ___/___/___ **Gender** ☐ **Female** ☐ **Male**

I request DNA analysis for the condition(s) _____

The intended purpose is: ☐ **Diagnosis** ☐ **Carrier status** ☐ **Predictive** ☐ **Prenatal**

☐ **Other** _____

I request that my (or my child's or my fetus') sample be tested for the above-designated genetic condition(s). My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional and I have been provided a copy of the corresponding technical bulletin describing testing for the condition(s) listed above.

1. DNA test results may:
   a) diagnose whether or not I have (or my child/fetus has) this condition or am at risk for developing this condition
   b) indicate whether or not I am (or my child/fetus is) a carrier for this condition
   c) predict another family member has or is at risk for developing this condition
   d) predict another family member is a carrier of this condition
   e) be indeterminate due to technical limitations or familial genetic patterns
   f) reveal non-paternity

2. DNA testing is specific to the condition(s) named above and will not detect all causative mutations.

3. The significance of a positive and a negative test result based on my family history has been explained.

4. Although DNA testing usually yields precise information, several sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, and inaccurate information regarding family relationships.

5. If a gene mutation is identified, insurance rates, obtaining disability or life insurance, and employability could be affected. Federal law extends some protections regarding genetic discrimination (http://www.genome.gov/10002328). It is my responsibility to consider the possible impact of these results. All test results are released to the ordering health care provider and those parties entitled to them by state and local laws.

6. The results are not intended to be used as the sole means for clinical diagnosis or patient management decisions.

7. DNA analysis is a fee-for-service test. I will be responsible for payment after the testing has begun, even if I decide not to receive results.

8. Genetic counseling is recommended prior to, as well as following, genetic testing.

Patient/Guardian Signature _____Date _____

Physician/Genetic Counselor:
I have explained DNA testing and its limitations to the patient or legal guardian and answered all questions.

Printed Name of Physician/Genetic Counselor _____ Date _____

Signature _____ Phone Number _____