VCGS Leaders in Genetic Health

Cardiac Genetics Test Request Form

Victorian Clinical Genetics Services
Murdoch Childrens Research Institute
The Royal Children's Hospital
Flemington Road, Parkville VIC 3052
P +61 3 8341 6201 F +61 3 8341 6366

PATIENT DETAILS				
LAST NAME	GIVEN NAMES	SEX	DATE OF BIRTH	LABORATORY REF
ADDRESS	POST CODE		PHONE (home)	MOBILE
REFERRER DETAILS				
LAST NAME	GIVEN NAMES		PHONE	FAX
DOCTOR'S SIGNATURE AND REQUEST DATE				
SIGNATURE:	DATE:		EMAIL	

TEST SELECTION (must be completed):

INDEX CASE TESTING:

ARRHYTHMIA PANELS

- ☐ Full arrhythmia panel (33 genes)
- ☐ Long QT syndrome panel (13 genes)
- ☐ Brugada syndrome panel (12 genes)
- ☐ MLPA screening (duplication & deletion)
  Long QT/Brugada (please circle) (5 genes)
- ☐ Catecholaminergic Polymorphic Ventricular Tachycardia panel (7 genes)
- ☐ Short QT syndrome panel (3 genes)
- ☐ Familial Atrial Fibrillation (4 genes)

CARDIOMYOPATHY PANELS

- ☐ Full cardiomyopathy panel (63 genes)
- ☐ Dilated cardiomyopathy (39 genes)
- ☐ Hypertrophic cardiomyopathy (34 genes)
- ☐ Arrhythmogenic right ventricular cardiomyopathy (8 genes)
- ☐ Left ventricular non-compaction cardiomyopathy (8 genes)
- ☐ Familial Atrial Fibrillation (4 genes)
- ☐ MLPA screening cardiomyopathy (duplication & deletion) (4 genes)

AORTOPATHY PANELS (Marfan, TAAD, Loeys Dietz, Ehlers Danlos, FAA)

- ☐ Full aortopathy panel (17 genes)

CONGENITAL CARDIAC DISORDERS PANELS

- ☐ Structural cardiac anomalies observed at birth (18 genes)

COMPREHENSIVE GENETIC CARDIAC DISORDERS PANELS

- ☐ All genes from the arrhythmia, cardiomyopathy & aortopathy panels (111 genes)

CUSTOM PANELS please indicate (up to 5 genes)

ADDITIONAL SERVICES:

- ☐ New family proband with known familial mutation
- ☐ Prenatal screening (prior discussion required)
- ☐ Re-analysis (prior discussion required)

☐ Cascade /carrier testing
Provide name & DOB of gene positive relative if tested by VCGS or gene report of gene positive relative together with control sample if the familial mutation was not identified by VCGS.

_____

_____

PATIENT CLINICAL DETAILS:

DIAGNOSIS: _____

AGE AT DX: _____ QTc INTERVAL: _____ms (if LQTS)

DIAGNOSIS STATUS:
- ☐ Certain
- ☐ Probable
- ☐ Uncertain

CLINICAL HISTORY:
- ☐ Syncope → (age if known) _____
- ☐ Seizures → (age if known) _____
- ☐ Cardiac arrest
- ☐ Neuromuscular disease
- ☐ Deafness

FAMILY HISTORY:

Are there any other affected relatives?
No/yes → (how many?) _____

Is there a history of sudden death related to the cardiac condition?
No/yes → (how many?) _____

Please provide a pedigree (de-identified is acceptable)

Billing

An invoice will be sent to the referring institution after the gene report is issued. If another provider/patient is funding the test, please provide a name and mailing address.

PROVIDER/PATIENT DETAILS		
LAST NAME	GIVEN NAMES	
ADDRESS	POST CODE	PHONE

SEND BLOOD SAMPLE & THIS REQUEST FORM TO:

Victorian Clinical Genetics Services
4th Floor, Murdoch Childrens Research Institute
The Royal Children's Hospital
50 Flemington Road, Parkville VIC 3052
P 03 8341 6201 W vcgs.org.au