

# FAMILIAL ARRHYTHMIA GENETIC TESTING REQUEST CLINICAL INFORMATION



## North of Scotland Genetics Service

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Clinical Genetics (*clinical enquiries only*)

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### PATIENT DETAILS (*printed label preferred*)

First Name(s)

Family Name

DOB

Sex

CHI

Pedigree No.

Address

Postcode

### Reason for testing (At least one should be present)

- Syncope  Arrhythmia  Choose an item. Abnormal ECG (see below)   
Seizure  Context of event: Choose an item. Family history (see below)   
Out of hospital cardiac arrest  Sudden cardiac death (<50 years)

Details:

### Suspected diagnosis:

Choose an item.

Details:

### ECG diagnosis

QTc:  Long QT  Short QT  Brugada  ARVC  LBBB  RBBB  IVCD  AV block

T wave: Normal  Notched  Inverted  Biphasic  Pre-excitation  Ajmaline test abnormal

Exposed to drug known to affect QT interval  Drug name:

Comments

### OTHER INVESTIGATIONS SUMMARY

**Echocardiogram** Normal  Abnormal  Not done  Details:

**MRI** Normal  Abnormal  Not done  Details:

**Autopsy** Details:

**Family History** SCD  Arrhythmia  Long QT  Brugada QT  ARVC  HCM  DCM  Other

### Which test are you requesting?

Choose an item.

Clinical Genetics contact:

Referring doctor:

### FAMILY PEDIGREE

Please clarify relationships of affected family members to the patient in this box:

Signed:

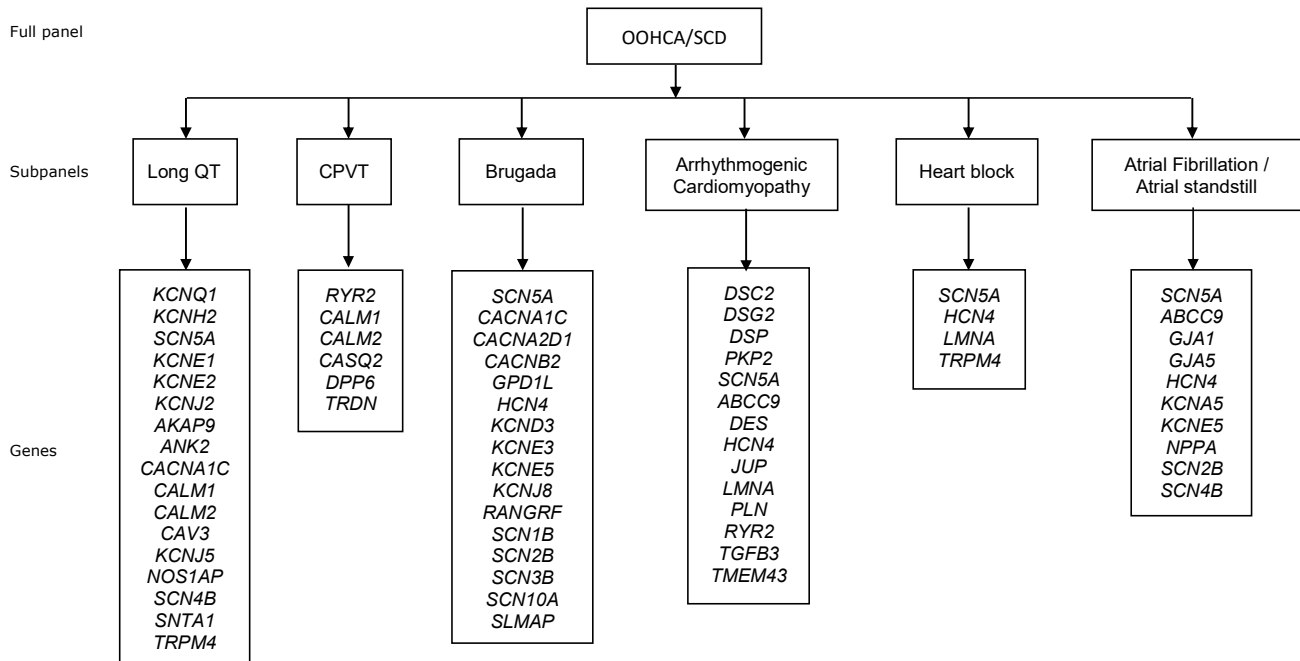
Date:

Consultant (Please Print)

**No testing will be undertaken until this form is completed and returned**

### Arrhythmia Panel and Subpanels

The genes shown will be analysed according to the clinical subpanel selected by the referring clinician.  
No analysis will take place if the form is incomplete.



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