REFERRAL FOR CARDIOVASCULAR DISEASE GENETIC TESTING

Please fax to 01223 281316 or scan and e-mail to Referral@GeneHealthUK.com

Please visit www.GeneHealthUK.com/referral for online submission

Patient Name: _____

DOB: _____

Address: _____

Phone number: _____

Indication for referral:

☐ Personal diagnosis of Inherited Cardiac Condition (ICC)
☐ First degree relative with an Inherited Cardiac Condition (ICC) but who is not available for genetic testing
Mother / Father / Sister / Brother (please indicate as appropriate)
(please provide information regarding their diagnosis with the referral)
☐ Relative with an Inherited Cardiac Condition (ICC) and known gene mutation

Gene mutation: _____

Relative: _____ (please attach copy of genetic report)

Please specify type of Inherited Cardiac Condition (ICC):

☐ Hypertrophic Cardiomyopathy (HCM)
☐ Dilated Cardiomyopathy (DCM)
☐ Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)
☐ Restrictive Cardiomyopathy
☐ Left Ventricular Non Compaction Cardiomyopathy
☐ LQT Syndrome
☐ Brugada Syndrome
☐ Catecholaminergic Polymorphic VT (CPVT)
☐ Other (please state) _____

Letter from Diagnosing Cardiologist attached: ☐ Yes ☐ No

Name of Cardiologist: _____

Referrer's Name and Title: _____

Referrer's Phone Number: _____

Referrer's Email: _____

Referrer's Hospital/Clinic: _____

Notes: _____

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