INVITAE

detect
Cardiomyopathy and Arrhythmia

Detect Cardiomyopathy and Arrhythmia Program Eligibility Criteria

FM194-3

Patients in the U.S. and Canada suspected of having a primary cardiomyopathy or arrhythmia are invited to take part in Detect Cardiomyopathy and Arrhythmia, a sponsored testing program for cardiomyopathy and arrhythmia.

The patient must meet the eligibility criteria below to qualify for the program. Please fill out, print, and sign this form and include it when sending in the specimen. Additional information about the ordering process can be found at www.invitae.com/detect-cardiomyopathy-arrhythmia

To submit orders for genetic testing outside of this program, please order through Invitae's online portal or use a standard requisition form here: www.invitae.com/forms.

Patient first name	Patient MI	Patient last name	Date of birth (MM/DD/YYYY)

DETECT CARDIOMYOPATHY AND ARRHYTHMIA PROGRAM ELIGIBILITY CRITERIA

This program is available to patients in the U.S. and Canada suspected of having a primary cardiomyopathy or arrhythmia.

REQUIRED CLINICAL HISTORY – (check all that apply)

◯ Suspicion or known diagnosis of a familial cardiomyopathy or arrhythmia
Diagnosis: ◯HCM ◯DCM ◯ARVC ◯LVNC ◯LQTS ◯CPVT ◯BrS ◯Other: _____
Age at diagnosis: _____
Index of clinical suspicion: ◯High ◯Moderate ◯Low

◯ Family history of a primary cardiomyopathy or arrhythmia
Diagnosis: ◯HCM ◯DCM ◯ARVC ◯LVNC ◯LQTS ◯CPVT ◯BrS ◯Other: _____

◯ Family history of unexplained sudden cardiac death
Age(s): _____

◯ Patient is deceased* ◯Yes ◯No

**If the patient is deceased please also complete the postmortem consent form located at www.invitae.com/postmortem-consent.*

CLINICAL HISTORY – DETECT CARDIOMYOPATHY AND ARRHYTHMIA PROGRAM

CLINICAL HISTORY	Y	N	UNKOWN
Syncope with stress	◯	◯	◯
Syncope without stress	◯	◯	◯
History of aborted SCD	◯	◯	◯
Congenital deafness	◯	◯	◯
Skeletal muscle weakness	◯	◯	◯

List other relevant history:

HISTOLOGICAL AND BIOCHEMICAL FINDINGS	Y	N	UNKOWN
Fibrofatty replacement of myocardium	◯	◯	◯
Amyloid-positive tissue biopsy	◯	◯	◯
Elevated creatine kinase	◯	◯	◯

ECG FINDINGS	Y	N	UNKOWN
Normal ECG	◯	◯	◯
AV Block	◯	◯	◯
Ventricular fibrillation	◯	◯	◯
Ventricular tachycardia	◯	◯	◯
Bidirectional VT	◯	◯	◯
Torsade de pointes	◯	◯	◯
T wave alternans	◯	◯	◯
Notched T wave in 3 leads	◯	◯	◯
Positive exercise stress test	◯	◯	◯
Low heart rate for age	◯	◯	◯
Cardiac conduction defects	◯	◯	◯
QTc interval	_____ mm		◯

List other relevant abnormalities:

CLINICAL HISTORY – DETECT CARDIOMYOPATHY AND ARRHYTHMIA PROGRAM (continued)

IMAGING FINDINGS	Y	N	UNKOWN
CMRI delayed enhancement	◯	◯	◯
LV noncompaction	◯	◯	◯
Dilation of the right ventricle	◯	◯	◯
Dilation of the left ventricle	◯	◯	◯
Myocardial scarring	◯	◯	◯
LV outflow tract obstruction	◯	◯	◯
LV ejection fraction	_____ %		◯
RV ejection fraction	_____ %		◯
Maximum LV wall thickness	_____ **mm**		◯
LV end systolic diameter	_____ **mm**		◯
LV end diastolic diameter	_____ **mm**		◯

List other relevant abnormalities:

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (www.invitae.com/forms). In connection with the Program the Patient has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated) and has been informed that de-identified Patient data may be used and shared with third parties, for research and commercial purposes and, in the U.S., to contact their medical professional. For orders originating in Canada, the Patient has been informed that their personal information and specimen will be transferred to and processed in the U.S. and that de-identified Patient data may be used and shared for research and commercial purposes in the U.S. The medical professional warrants that he/she will not seek reimbursement for this no-charge test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third parties, including commercial organizations, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that de-identified Patient data may be used and shared with such third parties, for purposes which include contacting their medical professional directly in connection with the Program. A list of third party partners may be provided upon request. I attest that I am authorized under applicable state law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**