Referral to CIDG for cardiac genetic evaluation of paediatric cardiomyopathy

Patient Details *(Attach patient sticker if available)*

Surname: _____ **NHI:** _____
First names: _____ **DOB:** _____
Gender: _____ **Ethnicity:** _____

Point of referral (OPD, ward, PICU):

Cardiac diagnosis (DCM/HCM, etc): _____

Comments (special echo or clinical features): _____

_____

_____

_____

_____

What do you request? *(tick the box)*

☐ Storage of DNA for possible testing - send sample to lab plus marked "CIDG storage/testing"
(CIDG will be made aware of the sample but will only test if a referral for an opinion is made)

AND/OR

☐ Opinion regarding genetic testing

For an opinion CIDG will require:

Have you considered a metabolic disease to be unlikely, or the metabolic team have already reviewed? Yes/No

Comments: _____

_____

_____

Is a genetic syndrome unlikely, or have the genetics team have already reviewed for dysmorphism, etc? Yes/No

Comments: _____

_____

_____

Is there a family history of cardiomyopathy? Yes/no

Comments: _____

_____

_____

Is there a family history of sudden death in young people? (<40) Yes/No

Comments: _____

_____

_____

Please provide: *(attached with referral)*

☐ A three generation family tree is drawn up and **attached to this form**

☐ Cardiac tests have been ordered for first degree relatives, **attach any results to this form**

☐ Confirm you have advised the family a referral has been made

☐ Contact person for the family:

Name: _____ **Position in family:** _____

Contact Details: Mobile: _____ Email: _____

Referrer (filling in this form): _____

Mobile: _____

Supervising Consultant: _____

Date: _____

Give this completed form and attachments to either;

- **Jackie Crawford** (CIDG coordinator) jackiec@adhb.govt.nz
- **Louise Monson** (CIDG team admin) CIDGAdmin@adhb.govt.nz
- **Jon Skinner** (CIDG clinical lead) JSkinner@adhb.govt.nz