



HCM/RCM screening within health programme

Participating clubs: see <http://www.pawpeds.com/healthprogrammes/hcmclubs.html>
 Visit <http://www.pawpeds.com/healthprogrammes/> for more information

586154
FREDRIKKE

Patient Information		Owner's name Roseanne och Daniella Forslund
Cat's registered name (N) Einhaugen's Fredrikke		Address Rådhusgatan 39 A
Registration number (SE) SVERAK RX 412738		Post code/City/State 852 32 Sundsvall
ID number, microchip or tattoo 578094100171939		Country Sweden
Breed of cat Snerian		Phone (including country code) +46 702292075
<input type="checkbox"/> Male <input checked="" type="checkbox"/> Not altered <input checked="" type="checkbox"/> Female <input type="checkbox"/> Altered		Email roseanne.forslund@telia.com
Born (year-month-day) 2022-09-29		I have read PawPeds' instructions for HCM screening. I am aware that I must inform the examiner about my cats health status and if it is on medication. I am aware that the results will be retained by PawPeds and that they will handle my personal data. I authorize PawPeds to publicly release the results from this form. Signature _____ Date _____
Sire NO*Lindviksmoen Linus		
Dam (N) Einhaugens Sol		
Examination		Examination date (year-month-day) 2023-10-23
Sedated <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		Examination equipment Philips Epiq 7
On medication <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		
Weight <u>3.4</u> kg BCS <u>4/9</u> Heart rate <u>162</u> bpm <input type="checkbox"/> Dehydrated <input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating <input type="checkbox"/> Other, describe _____	Auscultation: <input type="checkbox"/> Normal <input type="checkbox"/> Gallop <input type="checkbox"/> Murmur, characteristics Grade: I II III IV V VI <input type="checkbox"/> Dynamic <input type="checkbox"/> Static Timing: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Both <input type="checkbox"/> Continuous Location: <input type="checkbox"/> Left apex (sternum) <input type="checkbox"/> Left Base <input type="checkbox"/> Other, describe _____	
ECG Heart Frequency <u>157</u> IVSd <u>0.39</u> <input checked="" type="checkbox"/> cm <input type="checkbox"/> mm <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDd <u>1.41</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWd <u>0.35</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D IVSs <u>0.59</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDs <u>0.83</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWs <u>0.49</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D SF <u>41</u> Ao <u>1.04</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA <u>1.17</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA/Ao <u>1.13</u>	Subjective left atrial size <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Mild enlargement <input type="checkbox"/> Moderate enlargement <input type="checkbox"/> Severe enlargement Systolic anterior motion of the mitral valve <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, LV outflow tract flow velocity (Doppler) _____ End-systolic cavity obliteration <input type="checkbox"/> yes <input checked="" type="checkbox"/> no Papillary muscles <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal, moderate enlargement <input type="checkbox"/> Abnormal, severe enlargement	
Assessment (based on phenotype)		Comments
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Equivocal <input type="checkbox"/> HCM <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> RCM <input type="checkbox"/> Other, describe _____		
PawPeds' examination instructions has been followed Cat's identity verified <input checked="" type="checkbox"/> yes <input type="checkbox"/> no, describe why not _____		Veterinarian's name, clinic's name and address
Veterinary's signature _____ Date _____ _____ 23/10-23		
For registration of the result, the veterinarian shall send a copy of this form to: PawPeds, c/o Olsson, Ängsmyrvägen 1 Bäsna, SE-781 95 BORLÄNGE, Sweden		