





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

Patient Information		Owner's name Roseanne och Daniella Forslund
Cat's registered name Thomas Sibirela*BG		Address Rådhusgatan 39 A
Registration number LO 394372		Post code/City/State 852 32 Sundsvall
ID number, microchip or tattoo 100240000027235		Country Sverige
Breed of cat Sibirisk		Phone (including country code) +46 702292075
<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Not altered <input type="checkbox"/> Female <input type="checkbox"/> Altered		Email roseanne.forslund@telia.com
Born (year-month-day) 2021-04-22		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 23/3-23 
Sire Epic MiuMiuClub*RU		
Dam Eseniya Verooka* BFC-BY		
Examination		
Sedated <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		Examination date (year-month-day) 2023 07 23
On medication <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		Examination equipment PHILIPS CX50
Weight <u>5.2</u> kg BCS <u>5</u> Heart rate <u>234</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 checked="" type="checkbox"/> Murmur, characteristics Grade: I II <u>III</u> IV V VI <input checked="" type="checkbox"/> Dynamic <input type="checkbox"/> Static Timing: <input checked="" type="checkbox"/> Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Both <input type="checkbox"/> Continuous Location: <input type="checkbox"/> Left apex (sternum) <input checked="" type="checkbox"/> Left Base <input type="checkbox"/> Other, describe _____	
ECG Heart Frequency _____ IVSd <u>6.1</u> <input type="checkbox"/> cm <input checked="" type="checkbox"/> mm <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDd <u>13.5</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWd <u>4.8</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D IVSs <u>6.4</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDs <u>7.5</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWs <u>7.4</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D SF <u>442</u> Ao <u>9.8</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA <u>12.0</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA/Ao <u>1.2</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 checked="" type="checkbox"/> yes <input type="checkbox"/> no If yes, LV outflow tract flow velocity (Doppler) _____ End-systolic cavity obliteration <input checked="" type="checkbox"/> yes <input type="checkbox"/> no Papillary muscles <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Abnormal, moderate enlargement <input type="checkbox"/> Abnormal, severe enlargement	
Assessment (based on phenotype)		Comments
<input type="checkbox"/> Normal <input type="checkbox"/> Equivocal <input checked="" 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 _____ Veterinary's signature _____ Date 2023 07 23 		Veterinarian's name, clinic's name and address LENNART NILSSON Leg. veterinär Tfn 0709-79 88 61

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 BÖRLÄNGE, Sweden