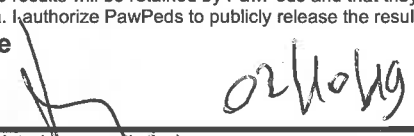





# HCM/RCM screening within health programme

Participating clubs: see <http://www.pawpeds.com/healthprogrammes/hcmclubs.html>

Visit <http://www.pawpeds.com/healthprogrammes/> for more information

<b>Patient Information</b>		Owner's name FALLER CHANTAL
Cat's registered name LAGERTHA DES BORDS DU RHIN	Address 49 QUAI DES ALPES	
Registration number LOOF 2015.21351	Post code/City/State 67000 STRASBOURG	
ID number, microchip or tattoo 250269606502350	Country FRANCE	
Breed of cat NORWEGIAN FOREST CAT	Phone (including country code) +33 620978433	
<input type="checkbox"/> Male <input checked="" type="checkbox"/> Not altered <input checked="" type="checkbox"/> Female <input type="checkbox"/> Altered	Email chantal2706@hotmail.fr	
Born (year-month-day) 2015-07-02	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. <b>Signature</b>  <b>Date</b> 02/10/15	
Sire TITRAN'S PLATO		
Dam FLORADORA DES BORDS DU RHIN		
<b>Examination</b>		
Examination date (year-month-day) 02/10/15		Examination equipment Pulsp HOI IS
Sedated <input type="checkbox"/> Yes, with: <input checked="" type="checkbox"/> No	On medication <input type="checkbox"/> Yes, with: <input checked="" type="checkbox"/> No	
Weight <u>5</u> kg BCS <u>300</u> Heart rate <u>185</u> bpm <input type="checkbox"/> Dehydrated <input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating <input type="checkbox"/> Other, describe	Auscultation: <input checked="" 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>185</u> IVSd <u>35</u> <input type="checkbox"/> cm <input checked="" type="checkbox"/> mm <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDd <u>170</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWd <u>37</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D IVSs <u>69</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDs <u>10</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWs <u>64</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D SF <u>389</u> Ao <u>91</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA <u>192</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA/Ao <u>124</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	
<b>Assessment (based on phenotype)</b> <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		Comments
PawPeds' examination instructions has been followed Cat's identity verified <input checked="" type="checkbox"/> yes <input type="checkbox"/> no, describe why not <b>Veterinary's signature</b>  <b>Date</b> 02/10/15		
Veterinarian's name, clinic's name and address <b>VETOSPHERE</b> Clinique Vétérinaire des Platanes Dr Poirier - N° Ordre 8749 13 rue de Wissembourg 67000 STRASBOURG 03 88 32 69 14		

For registration of the result, the veterinarian shall send a copy of this form to:  
PawPeds, c/o Olsson, Ångsmyrvägen 1 Bäsna, SE-781 95 BÖRLÄNGE, Sweden