



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 Hanna Bolhuis
Cat's registered name Miss Vaiana of Levinda		Address Meenteweg 13
Registration number NRKV 2021-1536		Post code/City/State 7971 RZ Havelte
ID number, microchip or tattoo 528257000150189		Country Nederland
Breed of cat Ragdoll		Phone (including country code) 0611717372
<input type="checkbox"/> Male <input checked="" type="checkbox"/> Not altered <input checked="" type="checkbox"/> Female <input type="checkbox"/> Altered		Email hanna_bolhuis3@hotmail.com
Born (year-month-day) 22-11-2021		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 2024- April-19
Sire Kenai of Furo Cats		
Dam Miss Nala of Levinda		
Examination		
Sedated <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		Examination date (year-month-day) 2024- April-19
On medication <input type="checkbox"/> Yes, with: _____ <input checked="" type="checkbox"/> No		Examination equipment JE vivid Q BT12
Weight <u>2.2</u> kg BCS <u>3/9</u> Heart rate <u>180</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>184</u> IVSd <u>3.21</u> <input type="checkbox"/> cm <input checked="" type="checkbox"/> mm <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDd <u>14.01</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWd <u>3.07</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D IVSs <u>4.96</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDs <u>6.42</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWs <u>5.84</u> <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D SF <u>54%</u> Ao <u>7.11</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA <u>10.74</u> <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA/Ao <u>1.51</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 <u>No echographic evidence of kidney disease (PKD, cin)</u>
<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 _____ Veterinary's signature _____ Date 2024- April-19		Veterinarian's name, clinic's name and address <u>Dr. Nick Beijerinck</u> <u>DVM, PhD, Dipl. ECVIM</u>
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		