



Patient Information		Owner's name	
Cat's registered name <i>Carsiana Avalanche</i>		<i>FARIHU AHMED</i>	
Registration number <i>MP0816624</i>		Address <i>M624 PETS, HANVAL U.M</i>	
ID number, microchip or tattoo <i>GH3148021060012</i>		Post code/City/State <i>PETS</i>	
Breed of cat <i>BEUGALI</i>		Country <i>HUN.</i>	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Not altered <input type="checkbox"/> Female <input type="checkbox"/> Altered		Phone (including country code) <i>2019851444</i>	
Born (year-month-day) <i>2017. 11. 02.</i>		Email <i>FRUITS@freail.com</i>	
Sex <i>PALMI HILLS MAID</i>		I have read PawPeds' instructions for HCM screening and am aware that I must inform the examiner about my cat's health status and if it is on medication. I am aware that the results will be retained for the records of PawPeds. I authorize PawPeds to publicly release all results from this form. Signature _____ Date <i>2018.10.30</i>	
Dom <i>RISUSUD CHATELONTE</i>		Examination date (year-month-day) <i>2018.10.30</i>	
Examination		Examination equipment <i>MILLSR4 DCS</i>	
Sedated <input type="checkbox"/> Yes, with: _____ <input type="checkbox"/> Yes, with: _____		Subjective left atrial size <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Mild enlargement <input type="checkbox"/> Moderate enlargement <input type="checkbox"/> Severe enlargement	
Weight _____ kg <i>6.</i>	Auscultation: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Murmur, characteristics	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	
Heart rate _____ bpm <i>150</i>	Grade: I II III IV V VI Timing: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic Location: <input type="checkbox"/> Left apex (sternum) <input type="checkbox"/> Left Base <input type="checkbox"/> Other, describe	Comments <i>HCM NEGATIVE</i>	
<input type="checkbox"/> Dehydrated <input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating <input type="checkbox"/> Other, describe	NSd _____ <input type="checkbox"/> cm <input checked="" type="checkbox"/> mm LVIDD _____ <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWd _____ <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D IVSS _____ <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVIDs _____ <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D LVFWs _____ <input checked="" type="checkbox"/> M-mode <input type="checkbox"/> 2-D SF _____ Ao _____ <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LA _____ <input type="checkbox"/> M-mode <input checked="" type="checkbox"/> 2-D LVAo _____		
Assessment (based on phenotype) <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 _____		Veterinarian's name, clinic's name and address <i>HCM NEGATIVE</i>	
PawPeds' examination instructions has been followed Cat's identity verified <input checked="" type="checkbox"/> yes <input type="checkbox"/> no, describe why not _____		ECHOCARD Műszeres Biológiai Központ 1135 Bp., László u. 43-47 T.: 239-7065, 06-309-245-006	
Signature _____ 			
Date <i>2018.10.30</i>			

For registration of the result, the veterinarian shall send a copy of this form to: