HOPITAL LARIBOISIERE
LABORATOIRE D'HISTO-EMBRYO-GENETIQUE MOLECULAIRE
Prof. E. TOURNIER-LASSERVE

INFORMATION SHEET TO BE COMPLETED WHENREQUESTING DIAGNOSTIC TESTING FOR FOR A *TREX1* CEREBRO-RETINIAL ANGIOPATHY

(Enclose detailed hospital chart)

Patient's first name : Last name:
Maiden name:
Date of birth: Age:

- **Clinical signs:** Enclose a hospital or consultation report

- **MRI:** A copy of the MRI T1, T2, gradient echo and Flair hypersignal films must be enclosed, either on Cd-Rom or using the conventional media.

- **Family tree with indication of the first and last names of patients including maiden names and married surnames. This can considerably speed up the results of examinations for patients who belong to families already known to our laboratory.**