ASSISTANCE PUBLIQUE HOPITAUX DE PARIS

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

INFORMATION SHEET TO BE COMPLETED WHEN REQUESTING DIAGNOSTIC TESTING FOR A *COL4A1* CEREBRO-RETINAL ANGIOPATHY

(Enclose a detailed hospital chart)

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

- **Clinical signs:** Enclose a hospitalisation and/or consultation report

- **MRI:** A copy of the MRI T1, T2, gradient echo and Flair scans must be provided, on either CD-Rom or conventional film.

- **Family tree with indication of the first and last names of patients including maiden and married names. This can considerably accelerate reporting on an examination of patients belonging to a family already known to our laboratory.**