1. What is your occupation?

- ◯ Consultant Clinical Geneticist
- ◯ Genetic Counsellor
- ◯ Trainee in Clinical Genetics
- ◯ Clinical Scientist
- ◯ Cardiologist

2. In which hospital do you work?

3. Please estimate what number of cardiac genetics patients are seen by your service each year

4. Is NGS-based inherited cardiac gene testing performed in the laboratory in your Genetics Centre?

- ◯ Yes
- ◯ No

5. If you do not perform NGS in house for this purpose, to which laboratory do you send your tests?

6. Do you have a sub-specialty interest in cardiac genetics or are you contracted to provide dedicated hours to cardiac genetics?

- ◯ yes
- ◯ no

7. Is there a consultant Clinical geneticist within your unit who is sub-specialised in cardiac genetics?

- ◯ Yes
- ◯ No
- ◯ I don't know

8. Do you routinely discuss test results with a clinical cardiology team in a multidisciplinary meeting?

- ◯ yes
- ◯ no
- ◯ I don't know

9. Considering DNA sequence variants classified as outlined here below:

Class 1 = Benign
Class 2 = Likely benign
Class 3 = Variant of unknown significance,
Class 4 = Likely pathogenic,
Class 5 = Pathogenic

please select a response to the following questions:

	Yes	No	Only to **AFFECTED** individuals for segregation analysis
Do you offer cascade testing to family members of a proband in whom a **class 5** variant is identified?	◯	◯	◯
Do you offer cascade testing to family members of a proband in whom a **class 4** variant is identified?	◯	◯	◯
Do you offer cascade testing to family members of a proband in whom a **class 3** variant is identified?	◯	◯	◯

10. Considering pre-test counselling for cascade testing of **CLASS 4** variants,

	Yes	No	I don't know/not sure
Not applicable, we never offer cascade testing for class 4 variants	○	○	○
Do you explain that there may be a degree of uncertainty about the pathogenicity of a **class 4** variant?	○	○	○
Do you mention the possibility of the pathogenicity classification changing as new evidence emerges in the future?	○	○	○

11. How often, in your opinion, should routine variant reclassification be performed? Please select one option

- ○ I do not think variant reclassification should be actively undertaken at all
- ○ Every 6 months
- ○ Annually
- ○ Every three years
- ○ Every five years

12. In an asymptomatic individual that has NORMAL predictive testing for a familial Class 4 variant, please answer the following:

	Yes	No	n/a - I would leave this decision to their cardiologist
Are you totally reassuring that they have no risk of developing the familial phenotype?	○	○	○
If they have not seen a cardiologist, do you refer them for assessment?	○	○	○
If they have seen a cardiologist and have no clinical signs, do you recommend discharge from follow-up?	○	○	○
Do you discuss their result at MDT meeting prior to making these clinical decisions?	○	○	○

13. Do you have any other concerns regarding the use of NGS for investigation of inherited cardiac pathology? If so, please list here below (optional)

14. Which of the following situtations should trigger variant reclassification? Please select all that apply

- [ ] Variant reclassification should be routinely performed as standard practice
- [ ] New data is generated regarding the variant from population databases (e.g. ExAC, gnomAD)
- [ ] An individual in a family receives a new diagnosis
- [ ] New literature is published regarding the variant
- [ ] New conflicting information regarding the familial phenotype comes to light
- [ ] Variant reclassification is mandated by the governing professional body (e.g. AGCS)