

**REGIONAL GENETICS LABORATORIES TEST REQUEST**

All tests requested will be reviewed against departmental criteria. If testing is not arranged, the samples will be stored and the referring clinicians informed. After testing, samples may be used anonymously for the development of new tests and for quality monitoring.

|  |                        |                            |   |
|--|------------------------|----------------------------|---|
| <b>Surname *</b>   | <b>Date of Birth *</b> | <b>Age at Presentation</b> | <b>Venous blood samples: Adult: 5ml; Children: 1-5ml</b><br><input checked="" type="checkbox"/> DNA test: EDTA tube   |
| <b>First Names *</b>   | <b>Sex *</b>           |                            |   |
| <b>NHS Number *</b>  | <b>Ethnicity</b>       |                            | <input type="checkbox"/> Microarray: Lithium Heparin and EDTA tubes   |
| <b>Hospital Number * (If known)</b>  | <b>Family Number</b>   |                            | <b>Other samples:</b>   |
| <b>Home Address *</b>  |                        |                            | <input type="checkbox"/> Cord/Placenta/insertion site/skin  |
| <b>Postcode</b>  |                        |                            | <input type="checkbox"/> Products of Conception (whole specimen in sterile pot)   |
| <b>Patient email address</b>   |                        |                            | <input type="checkbox"/> Amniotic Fluid   |
| <b>GP Name (Printed) *</b>   |                        |                            | <input type="checkbox"/> CVS  |
| <b>GP Address</b>  |                        |                            | <input type="checkbox"/> Other (please contact the laboratory)  |
| <b>Postcode</b>  |                        |                            | <b>Sample obtained by (Signature).....</b>  |
| <b>GP email address (nhs.net preferred)</b>  |                        |                            | <b>Printed Name .....</b>   |
| <b>Consultant (PRINT)</b><br>Dr WJH Griffiths  |                        |                            | <b>Date.....</b>  |
| <b>Hospital</b><br>Addenbrooke's Hospital  |                        |                            | <b>Billing to:</b>  |
| <b>Speciality/Dept/Ward</b><br>Liver Unit Box 210  |                        |                            | <b>Private Patient:</b> <input type="checkbox"/>  |
| <b>Contact telephone number</b>  |                        |                            | <b>In Submitting this sample, the clinician confirms * that consent has been obtained for:</b>  |
| <b>Email address (nhs.net preferred)</b>   |                        |                            | a) Testing and Storage<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <b>Results to (if different from above) inc email address (nhs.net preferred)</b>  |                        |                            | b) The use of this sample and the information generated from it to be shared with members of the patient's family and their health professionals (if appropriate)<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Clinical Synopsis</b> Please provide clinical synopsis and pedigree with relevant family history to help the team generate a laboratory report *  |                        |                            |   |
| <b>Tests Required:</b><br>HFE1 p.(Cys282Tyr) and p.(His63Asp) genotypes.<br>Please send EDTA tube to Regional Genetics Laboratory (See address overleaf).<br><b>Storage Only (no testing at this time):</b> <input type="checkbox"/> |                        |                            |   |
| <b>Gestation in weeks (If pregnant):</b>   |                        |                            |   |
| <b>Partners Name and DOB:</b>  |                        |                            |   |
| <b>Index Case (if not this patient):</b>   |                        |                            |   |

The Laboratory does NOT report results via the telephone

**All samples MUST be labelled with FULL name, date of birth and NHS number  
Processing of samples will be delayed if information is incomplete**

Send samples at room temperature by 1<sup>st</sup> class post or courier to:  
**East Anglian Medical Genetics Service, Genetics Laboratories, Box 143  
ATC Level 6, Addenbrooke's Hospital, Hills Road, Cambridge, CB2 0QQ**

Laboratory opening hours: 8.30am - 5.30pm Monday to Friday  
Telephone: 01223 348866 Fax: 01223 348712  
E-mail: geneticslaboratories@nhs.net

**For further information about sample requirements and tests available see: [www.cuh.org.uk/genetics-labs](http://www.cuh.org.uk/genetics-labs)**

**Indication for Genetic Testing:**

- 1. To establish a diagnosis
- 2. Guide clinical management
- 3. Information regarding prognosis/recurrence risk
- 4. Predictive testing
- 5. PGD/Prenatal diagnosis
- Has the test been discussed at a clinical meeting?  
If so, please provide information on clinical meeting  
(i.e.: Neurology meeting, cancer meeting)
- Is the test urgent?  
(i.e. pregnant or will alter management)
- Please confirm that your department will fund the test\*
- Has the test been approved by patient's consultant

\* Please see UKGTN website (<http://ukgtn.nhs.uk/>) for approximate cost or contact the duty scientist (tel: 01223 348866)

**CUH Laboratory Use Only:**

|   |                           |
|---|---------------------------|
| <b>Receipt date and time:</b>                     | <b>Other Information:</b> |
| <b>Tube type:</b> <b>Volume:</b>                  |                           |
| <b>No of tubes:</b>                               |                           |
| <b>Shire Only</b> <input type="checkbox"/>        |                           |
| <b>Patient Demographics Checked:</b>              |                           |
| <b>Send out approved by:..... Signature:.....</b> |                           |
| <b>Date:.....</b>                                 |                           |