* Information required prior to sending to Genetics

Cambridge University Hospitals NHS
NHS Foundation Trust

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.

Surname *	**Date of Birth** *	**Age at Presentation**
First Names *		**Sex** *
NHS Number *		**Ethnicity**
Hospital Number * (If known)	**Family Number**	

Home Address *

Postcode

Patient email address

GP Name (Printed) *

GP Address

Postcode

GP email address (nhs.net preferred)

Consultant (PRINT)	**Hospital**

Speciality/Dept/Ward

Contact telephone number

Email address (nhs.net preferred)

Results to (if different from above) **inc email address (nhs.net preferred)**

Venous blood samples: Adult: 5ml; Children: 1-5ml

☑ DNA test: EDTA tube

☐ Chromosomes: Lithium Heparin tube

☐ Microarray: Lithium Heparin and EDTA tubes

Other samples:

☐ Cord/Placenta/insertion site/skin

☐ Products of Conception (whole specimen in sterile pot)

☐ Amniotic Fluid

☐ CVS

☐ Other (please contact the laboratory)

Sample obtained by (Signature)……

Printed Name ……..

Date…….

Billing to:

Private Patient: ☐

In Submitting this sample, the clinician confirms that consent has been obtained for: *

a) Testing and Storage
☐ Yes ☐No

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)
☐Yes ☐No

Clinical Synopsis

Please provide clinical synopsis and pedigree with relevant family history to help the team generate a laboratory report *

Tests Required:

HFE1 p.(Cys282Tyr) and p.(His63Asp) genotypes.

Please send EDTA tube to Regional Genetics Laboratory (See address overleaf).

Storage Only (no testing at this time): ☐

Gestation in weeks (If pregnant):

Partners Name and DOB:

Index Case (if not this patient):

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 1st 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

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:

Receipt date and time: **Tube type:** **Volume:** **No of tubes:** **Shire Only** ☐ **Patient Demographics Checked:**	**Other Information:**
Send out approved by:…….. Signature:…… **Date:……**	