



GENETIC TEST REQUEST FORM

Please note that forms with missing patient identifiers or no referring clinician/facility may not be tested

SURNAME		FIRST NAME		LAB REF: <small>Lab use only</small>	
DATE OF BIRTH		GENETIC ID		SAMPLE TYPE	
		NHS NUMBER		URGENT / ROUTINE	
SEX	ETHNIC ORIGIN	HOSPITAL NO		DATE / TIME COLLECTED	
				DATE / TIME RECEIVED	
				<small>Lab use only</small>	
PATIENT ADDRESS & POSTCODE					
GP NAME & ADDRESS					
			NHS	PRIVATE	
			CCG CODE		
REFERRING CONSULTANT (Full name required)					
DEPARTMENT (Required)			SUBMITTER ID (GOSH LINK)		
HOSPITAL (Required)			NHS.NET EMAIL / CONTACT NUMBER		

HIGH RISK? YES^N NO
If yes, please specify:
(Mandatory field)

SAMPLE TAKEN BY:

REASON FOR REFERRAL
Please give clinical details

MOLECULAR GENETIC TEST (EDTA):

Specify disease / gene test(s) and provide any relevant family history:

DNA STORAGE ONLY

DIAGNOSTIC TEST

CARRIER TEST

PREDICTIVE TEST

NIPD

MICROARRAY (EDTA and LITHIUM HEPARIN): Please confirm patient has one of the following:

Developmental Delay Dysmorphism Multiple congenital abnormalities Epilepsy

Please provide full clinical details including family history above.

MICROARRAY FAMILY FOLLOW UP (EDTA AND LITHIUM HEPARIN)

Please give name and laboratory number of index patient.

Rapid testing (LITHIUM HEPARIN (Infants under 3 months) for:

Trisomy 21

Trisomy 13 Trisomy 18

Chromosomal sex

Please also select microarray or karyotype.

KARYOTYPING (LITHIUM HEPARIN)

Mosaicism suspected? please give details.

INSTRUCTIONS:

The sample tube and referral card must have three matching identifiers to be accepted. Patient's gender must be indicated on the request form.

BLOOD SAMPLES: Mix samples thoroughly for 2 minutes to prevent clotting

5mls venous blood in plastic EDTA (pink or lavender) bottles (>1ml from neonates)

2mls venous blood in plastic Lithium Heparin (orange or green) bottles (1-2ml from neonates)

Lithium Heparin blood samples must be received in lab within 24 hours (refrigerate overnight at 4°C if necessary).

For free fetal (NIPD) analysis please send 20ml blood (EDTA) – Contact Lab in advance

ANY OTHER SAMPLE e.g. Prenatal, Buccal swab – TELEPHONE FOR ADVICE

Sample must be labelled with:

- Patient's full name (surname and given name)
- Date of birth and NHS number
- Referring Hospital Number
- It is desirable to have the date and time sample was taken and/or location

NOTE: Samples in glass bottles will not be accepted
UNLABELLED Samples will not be accepted
MISLABELLED Samples will result in delay

Samples coming from outside Great Ormond Street Hospital / Institute of Child Health must be packaged in accordance with **UN PACKING REQUIREMENT PI 650** and clearly labelled '**diagnostic specimen UN3373**'

Sample Handling:

Samples can be shipped at room temperature. Samples may be stored at room temperature if taken on the day they are to be sent or refrigerated overnight.

Samples in **Streack Tubes** for Non-Invasive Prenatal Diagnosis/Testing must be stored at room temperature and NOT refrigerated.

Address to:

Specimen Reception

Level 5, Barclay House

Great Ormond Street Hospital

37 Queen Square

London WC1N 3BH

Tel: 020 7829 8870 Fax: 020 7813 8578 Email: genetics.labs@gosh.nhs.uk

For details of all referral criteria and policies please see our website:

<http://www.labs.gosh.nhs.uk/laboratory-services/genetics>

For Lab Use Only