UKAS MEDICAL 7883

# North East Thames Regional Genetics Service Laboratory

Great Ormond Street Hospital for Children NHS Foundation Trust

# GENETIC TEST REQUEST FORM

| | | |
|---|---|---|
| SURNAME | | FIRST NAME |
| DATE OF BIRTH | GENETIC ID | NHS NUMBER |
| SEX | ETHNIC ORIGIN | HOSPITAL NO |
| PATIENT ADDRESS & POSTCODE | | |
| GP NAME & ADDRESS | | NHS / PRIVATE<br>CCG CODE |
| REFERRING CONSULTANT | | |
| ADDRESS FOR REPORT | | NHS.NET EMAIL / CONTACT NUMBER |

| | |
|---|---|
| LAB REF: | |
| SAMPLE TYPE | URGENT / ROUTINE |
| DATE / TIME COLLECTED | DATE / TIME RECEIVED |
| 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.**

☐ **KARYOTYPING (LITHIUM HEPARIN)**

☐ **Mosaicism suspected? please give details.**

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

☐ **Trisomy 21**
☐ **Trisomy 13** ☐ **Trisomy 18**
☐ **Chromosomal sex**

**Please also select microarray or karyotype.**

**Consent is not required for DNA storage. It is the responsibility of the clinician to obtain consent before requesting a genetic test**

## 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$^{o}$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 **Streck 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**