CPA
Accredited Medical Laboratory
Reference No: 2645

MOLECULAR GENETICS REQUEST

RILD Level 3
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SURNAME:	D.O.B.:	GP NAME:	CONSULTANT (FULL NAME):	
FORENAME(S):	GENDER:	GP SURGERY NAME (or CODE):	HOSPITAL (IN FULL):	
NHS NUMBER:	PATIENT'S POSTCODE:	GENETICS NUMBER:	DEPARTMENT:	TELEPHONE /EMAIL:
HOSPITAL NUMBER:	NHS ☐ PRIVATE: ☐	ETHNIC ORIGIN:	COPY REPORT TO (NAME AND LOCATION):	

MUTATION SCREEN/DIAGNOSTIC TEST: ☐
PREDICTIVE/PRESYMPTOMATIC TEST: ☐
AFFECTED – CONFIRMATION OF FAMILIAL MUTATION: ☐
CARRIER TEST: ☐
PRENATAL TEST: ☐
STORAGE ONLY:
- DNA ☐
- RNA ☐
- TISSUE ☐

EXPORT (Please provide forwarding details if known) ☐

Where appropriate, please provide details of the familial mutation(s), name of relative with mutation(s) and their relationship to this patient.

INVESTIGATION(S) REQUIRED:

CLINICAL DETAILS: (Disease-specific forms can be downloaded from www.rdehospital.nhs.uk/prof/molecular_genetics)

SAMPLE TYPE

BLOOD (Adults: 2x 4ml, Children 1-4ml in 4ml EDTA tubes): ☐
BUCCAL/SALIVA: ☐
BONE MARROW: ☐
SOLID TISSUE: ☐
Origin:
Histology No.:

OTHER: ☐
Type:

DATE SAMPLE TAKEN:
SAMPLE TAKEN BY:

CONSENT: In submitting this sample, the clinician confirms that **informed consent** has been obtained for (a) testing and storage (b) the use of this sample and the information generated from it to be shared with members of the donor's family and their health professionals (if appropriate). The patient should be advised that the sample may be used anonymously for quality assurance and training purposes.

Name of Clinician:
Date: