



8092

MOLECULAR GENETICS REQUEST

RILD Level 3
 Royal Devon & Exeter NHS Foundation Trust
 Barrack Road, Exeter, EX2 5DW
Tel: 01392 408229
Fax: 01392 408388
<https://www.exeterlaboratory.com/molecular-genetics/>
 Rde-tr.ExeterGenomicsLaboratory@nhs.net

SURNAME:		GENETICS NUMBER:		CONSULTANT (FULL NAME):		COPY REPORT TO (FULL NAME):	
FORENAME(S):		NHS: <input type="checkbox"/>	PRIVATE: <input type="checkbox"/>	CONSULTANT HOSPITAL & ADDRESS (IN FULL):		COPY TO HOSPITAL & ADDRESS (IN FULL):	
NHS NUMBER:		GP NAME:					
D.O.B:	PATIENT'S POSTCODE:	GP SURGERY NAME:	DEPARTMENT:	TELEPHONE /EMAIL:	REPORT TO DEPARTMENT	REPORT TO TELEPHONE/EMAIL	
GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>	ETHNIC ORIGIN:	GP Email:	INVOICE TO:		INVOICE ADDRESS:		

INVESTIGATION(S) REQUIRED:

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.

CLINICAL DETAILS: (Disease-specific forms can be downloaded from <https://www.exeterlaboratory.com/molecular-genetics/>)

MUTATION SCREEN/DIAGNOSTIC TEST:

PREDICTIVE/PRESYMPTOMATIC TEST:

AFFECTED – CONFIRMATION OF FAMILIAL MUTATION:

CARRIER TEST:

PRENATAL TEST:

STORAGE ONLY:

DNA

RNA

TISSUE

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: