UKAS MEDICAL 7883

Rare & Inherited Disease Genomic Laboratory
Great Ormond Street Hospital for Children NHS Foundation Trust
Level 5 Barclay House, 37 Queen Square, London WC1N 3BH

NHS London North
NHS Genomic Laboratory Hub

GENETIC TEST REQUEST FORM

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

SURNAME		**FIRST NAME**
DATE OF BIRTH	**GENETIC ID**	**NHS NUMBER**
SEX	**ETHNIC ORIGIN**	**HOSPITAL NO**
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**

LAB REF: Lab use only	
SAMPLE TYPE	**URGENT / ROUTINE**
DATE / TIME COLLECTED	**DATE / TIME RECEIVED** Lab use only
HIGH RISK? YES☐ 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.

☐ **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