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 North Thames 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	**GOSH FAMILY ID**	**NHS NUMBER**
SEX	**ETHNIC ORIGIN**	**HOSPITAL NO / YOUR REF**

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 in Streck or PAXgene ccfDNA cell-stabilising tubes – 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 / 020 7762 6888 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