

**THE FORM MUST BE COMPLETED FULLY IN BLACK INK. THE SPECIMEN CONTAINER AND FORM MUST BE LABELLED WITH TWO MATCHING PATIENT IDENTIFIERS, OTHERWISE THE SPECIMEN WILL BE REJECTED.**

(SEE OVERLEAF FOR SAMPLE REQUIREMENTS)

## PATIENT DETAILS

STICK YOUR PRINTED LABEL OVER THIS SECTION IF AVAILABLE

FAMILY NAME	<input type="text"/>	POSTCODE	<input type="text"/>
FIRST NAME(S)		PEDIGREE/REFERENCE	<input type="text"/>
DATE OF BIRTH		HOSPITAL NUMBER	<input type="text"/>
CHI/NHS NUMBER		SEX	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN <input type="checkbox"/>
		ETHNIC ORIGIN if relevant eg. for CF	<input type="text"/>

## REFERRING CONSULTANT (FOR REPORTING)

CONSENT: It is the referring clinician's responsibility to obtain informed consent from the patient/carer for the test and for sample storage for any future diagnostic test. Consent is implied by submitting the sample for testing.

CLINICIAN	<input type="text"/>	ADDRESS	<input type="text"/>
TELEPHONE	<input type="text"/>		<input type="text"/>
EMAIL	<input type="text"/>	POSTCODE	<input type="text"/>
IF TESTING IS CHARGEABLE, PLEASE SUPPLY A PURCHASE ORDER OR REFERENCE NUMBER			<input type="text"/>

## REASONS FOR REFERRAL/CLINICAL INDICATION

CLINICAL DETAILS/ADDITIONAL INFORMATION/SPECIAL REQUESTS

IS THE PATIENT CLINICALLY AFFECTED?	YES <input type="checkbox"/> NO <input type="checkbox"/>	IS THERE A FAMILY HISTORY?	YES <input type="checkbox"/> NO <input type="checkbox"/>
IS THE PATIENT PREGNANT?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>	
HOW MANY WEEKS GESTATION?	<input type="text"/> URGENT <input type="checkbox"/>		

## TEST REQUEST

TICK WHICH TEST(S) YOU WISH TO REQUEST FROM US

- DNA ANALYSIS (MAY REQUIRE CLINICAL GENETICS APPROVAL)
- DNA EXTRACTION AND STORAGE ONLY
- MICROARRAY
- CHROMOSOMES/KARYOTYPE
- PRENATAL DIAGNOSIS (INCLUDING QF-PCR)

SAMPLE TYPE YOU MUST SEND TO US

<b>BLOOD EDTA</b>	
<b>BLOOD EDTA</b>	
<b>BLOOD LiHEP</b>	AND <b>BLOOD EDTA</b>
<b>BLOOD LiHEP</b>	AND <b>BLOOD EDTA</b>
<input type="checkbox"/> CVS OR <input type="checkbox"/> AF	AND <b>BLOOD EDTA</b>

ADDITIONAL INFORMATION

OTHER SAMPLE TYPE

<input type="checkbox"/> POC	<input type="checkbox"/> TISSUE	<input type="checkbox"/> TUMOUR
<input type="checkbox"/> FFPE TISSUE	<input type="checkbox"/> ORAGENE	<input type="checkbox"/> BUCCAL SMEAR

## SAMPLING DETAILS

HIGH INFECTION RISK <input type="checkbox"/>	BLEEP <input type="text"/>	TAKEN BY <input type="text"/>
DATE <input type="text"/>	TIME <input type="text"/>	TELEPHONE <input type="text"/>

FOR LAB USE ONLY

## INSTRUCTIONS AND SPECIMEN REQUIREMENTS

All specimens should be clearly labelled with surname, forename and date of birth/CHI number and these details must match those supplied on the test referral form. If the specimen label does not match the information that is supplied on the test referral form, the sample will be discarded.

Please ensure other labels e.g. those which are added to the specimen tube by other laboratories, do not obscure the original specimen label containing the patient identifiers (name and date of birth/CHI number) or the specimen may be rejected.

The specimen should be placed in a sealed plastic bag containing absorbent material, with the accompanying referral form placed in a separate compartment, preventing contamination in the event of leakage.

Blood and fluid specimens sent through the post should be packaged in accordance with PI 650 and UN3373 regulations.

SPECIMEN	CONTAINER	VOLUME	DELIVERY/COMMENTS
<b>BLOOD SPECIMENS</b>			
<b>To enable automated processing, please use 4ml containers for collection of adult/paediatric blood specimens.</b>			
Molecular DNA investigations (and/or storage)	EDTA (KE)	Adult/Paediatric-3ml Newborn-1ml	Same day
Microarray analysis	Lithium heparin and EDTA (KE)	Adult/Paediatric-3ml Newborn-1ml (in each tube)	Same day
Karyotype (chromosome analysis) only	Lithium heparin	Adult/Paediatric-3ml Newborn-1ml	Same day
Rapid aneuploidy/chromosomal sex screen	Lithium heparin and EDTA (KE)	Newborn-1ml (in each tube)	Same day
<b>OTHER SPECIMENS FOR CHROMOSOME AND DNA INVESTIGATIONS (including QF-PCR)</b>			
Amniotic fluid Maternal blood also required 3ml EDTA (KE) tube	Sterile 20ml universal	15-20ml	Same day
Chorionic villus biopsy (CVS) Maternal blood also required 3ml EDTA (KE) tube	Sterile 20ml universal containing transport medium	10 – 20 mg of villus for most referrals	Same day CVS transport medium supplied by the laboratory
Products of conception (PoC)	Dry, well-sealed container		Same day Should NOT be placed in formalin fixative. Include appropriate consent forms.
Skin/other tissue	Sterile 20ml universal containing transport medium		Same day transport medium supplied by the laboratory

If a delay in sending a specimen is unavoidable, blood and solid tissue specimens should be refrigerated overnight, specimens for prenatal diagnosis (AF or CVS) should be stored at room temperature. DO NOT FREEZE.

If further copies of this form are required please contact the laboratory on 0141 354 9300 or email [geneticlabs@ggc.scot.nhs.uk](mailto:geneticlabs@ggc.scot.nhs.uk)  
A copy of this request form can be downloaded from the Department's web page [www.nhsggc.org/medicalgenetics](http://www.nhsggc.org/medicalgenetics)