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|  | | | | | | | **DPYD Test Request Form**    **North West Genomic Laboratory Hub (Liverpool)** | | | | | | | | | | **Lab use only** | | | | | |
| **Lab sticker:** | | | | Type Lab No. or Affix label | |
| (DOC6115 Revision 4) | | | | | | | | | |
| **Patient Details** – use sticker if available but please add any missing information | | | | | | | | | | | | | | | | **Referring Clinician/Healthcare Professional** | | | | | | |
| **NHS No:** | Enter NHS No | | | | | | | | **D.O.B.:** | | DD/MM/YYYY | | | | | **Consultant/GP:**  (in full) | Enter Consultant/GP name | | | | | |
| **Surname:** | Enter Surname | | | | | | | | **Hospital Number:** | | Enter Biological Sex | | | | | **E-mail/Tel:** | Enter E-mail/Tel. | | | | | |
| **Forename:** |  | | | | | | | | **NHS/**  **Private** | |  | | | | | **Hospital/Surgery:**  (in full) |  | | | | | |
| **Patient’s Address:** | Enter Forename  Address Line 1 | | | | | | | | **Biological Sex:** | | Enter Gender Identity | | | | | **Department:** | Enter Hospital/Surgery | | | | | |
| **Postcode:** | **Gender Identity:** | | Enter Ethnicity | | | | | **Requested by/ Cc. Report to:** | Enter Department  Enter Requested by/Cc. Report to | | | | | |
| Address Line 2 | | | | | | | |
| Address Line 3  Postcode | | | | | | | | **Ethnicity:** | | Enter Hospital No | | | | |
| **Consent Statement**: Receipt of this form and sample(s) by the laboratory assumes that the clinician has obtained consent for genomic testing and for the use of the DNA/RNA sample(s) and/or test result(s) by healthcare professionals in the UK. | | | | | | | | | | | | | | | | | | | | | | |
| **DPYD testing required - please select option below by placing a tick or cross next to relevant clinical indication for DPYD testing** Refer to National Genomic Test Directory (<https://www.england.nhs.uk/publication/national-genomic-test-directories/>). | | | | | | | | | | | | | | | | | | | | | | |
| **CI Code\*** | | **Clinical Indication Name** | | | | | | | | | | | | | | | | | **Test Code** | | | **Please tick** |
| M1 | | Colorectal Carcinoma | | | | | | | | | | | | | | | | | M1.7 | | |  |
| M3 | | Breast Cancer | | | | | | | | | | | | | | | | | M3.7 | | |  |
| M6 | | Mucoepidermoid Carcinoma | | | | | | | | | | | | | | | | | M6.5 | | |  |
| M14 | | Adrenal Cortical Carcinoma | | | | | | | | | | | | | | | | | M14.5 | | |  |
| M15 | | Head and Neck Squamous Cell Carcinoma | | | | | | | | | | | | | | | | | M15.7 | | |  |
| M16 | | Adenoid Cystic Carcinoma | | | | | | | | | | | | | | | | | M16.4 | | |  |
| M17 | | Secretory Carcinoma (Salivary Gland) | | | | | | | | | | | | | | | | | M17.4 | | |  |
| M219 | | Pancreatic Cancer | | | | | | | | | | | | | | | | | M219.3 | | |  |
| M220 | | Cholangiocarcinoma | | | | | | | | | | | | | | | | | M220.3 | | |  |
| M222 | | Hepatocellular carcinoma | | | | | | | | | | | | | | | | | M222.4 | | |  |
| M226 | | Cancer of Unknown Primary | | | | | | | | | | | | | | | | | M226.3 | | |  |
| M227 | | Solid tumour other (i.e. specific histology not listed elsewhere in the test directory) | | | | | | | | | | | | | | | | | M227.3 | | |  |
| M236 | | Oesophageal Cancer | | | | | | | | | | | | | | | | | M236.2 | | |  |
| M237 | | Gastric Cancer | | | | | | | | | | | | | | | | | M237.2 | | |  |
| M238 | | Small Bowel Cancer | | | | | | | | | | | | | | | | | M238.2 | | |  |
| **Clinical Details** | | |  | | | | | | | | | | | | | | | | | | | |
| **Sample Type:** | | | | | | | | | | | | | | | | | | | | | | |
| **High Infection Risk?** | | | |  | Yes |  | | No | | **Sample Date:** | | | | | Select Date from Calendar | | | **Taken by:** | | Enter Full Name | | |
| **Does this patient have a blood-borne infection? If yes PLEASE STATE:** | | | | | | | | | |  | | | | | | | | | | | | |
| North West Genomic Laboratory Hub (LIVERPOOL)  Manchester Centre for Genomic Medicine,  Liverpool Women’s Hospital,  Crown Street,  Liverpool, L8 7SS | | | | | | | | | | | | | | Tel: 0151 702 4228 / 4229  Email: [mft.genomics@nhs.net](mailto:mft.genomics@nhs.net) | | | | | | | | |
| **Guidance Notes – Molecular Genomic Testing Request Form – DPYD Testing** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Details** | | | | | | | | | | | |  | **Specimen Details** | | | | | | | | | |
| The following details are mandatory, other details should be completed as fully as possible:   * **Surname** & **Forename** * **D.O.B** – Date of Birth * **NHS Number** (10 digits) * Patient’s **Biological Sex** * Patient’s **Postcode**   Please ensure a minimum of 3 matching identifiers on tubes and form. | | | | | | | | | | | | **High Infection Risk:** In accordance with the Health & Safety at Work Act and COSHH Regulations, the laboratory must be informed of any infection risk associated with submitted samples. The sender has the responsibility for minimising the risk to laboratory staff by giving sufficient information to enable the laboratory to take appropriate safety precautions when testing a specimen.  **Sample Type**: EDTA peripheral blood can be sent for all tests  **Sample Volume:** 3mls adults; 1-2ml from young children.– MIX WELL and store at 4°C.  **Sample Packaging:** The sample container should be sealed in a biohazard bag in case of a leakage. To prevent contamination of referral form and paperwork this should not be sealed with the sample. All packaging should conform to UN650 standards (as applied to UN3373 – Biological Samples, Category B). | | | | | | | | | |
| **Referring Clinician/Healthcare Professional** | | | | | | | | | | | |
| The following details are mandatory:   * **Consultant/GP name**: initials are not acceptable as the laboratory cannot identify the clinician/healthcare professional. A minimum of first initials and surname must be provided. * **Hospital** should be clearly identifiable; initials are not acceptable as the laboratory cannot identify the hospital. Trusts with more than one hospital should clearly identify the referring hospital. * **Department** should be clearly identifiable; initials are not acceptable as the laboratory cannot identify the department.   **Requested by/Cc. Report to:** Use this space if the healthcare professional requesting the test/requiring a report copy is not the patient’s Consultant. | | | | | | | | | | | |
| **This area is for Lab use only** | | | | | | | | | | | | | | | | | | | | | | |