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|  | **Molecular Genomic Testing** **Request Form****HAEMATO-ONCOLOGY** | **Haem-Onc DS Triage - Lab use only** |
| **Lab No:** | Type Lab No. or Affix label |
| (DOC5775 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 | **Biological Sex:** | Enter Biological Sex | **E-mail/Tel:** | Enter E-mail/Tel. |
| **Forename:** | Enter Forename | **Gender Identity:** | Enter Gender Identity | **Hospital/Surgery:** (in full) | Enter Hospital/Surgery |
| **Patient’s Address:** | Address Line 1 | **Ethnicity:** | Enter Ethnicity | **Department:** | Enter Department |
| Address Line 2 |
| Address Line 3 | **Hospital No:** | Enter Hospital No | **Requested by/ Cc. Report to:** | Enter Requested by/Cc. Report to |
| **Postcode:** | Postcode |
| **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. |
| **Test Required (please select options by placing a tick or cross next to each test required).** Refer to National Genomic Test Directory (<https://www.england.nhs.uk/publication/national-genomic-test-directories/>). |
| **Test**  | **Required** | **Other PCR-based tests**  | **Required** |
|  Myeloid NGS panel options: | B Cell Clonality **(DNA)** |  |
| New diagnosis AML (includes rapid *FLT3* and *NPM1*, Myeloid panel and RNA store) **(DNA/RNA store)** |  | T Cell Clonality **(DNA)** |  |
| MPN Panel (*JAK2* V617F and exon 12, *CALR* and *MPL*) **(DNA)** |  | Systemic mastocytosis (*KIT*) **(DNA)** |  |
| Myeloid panel (e.g. cytopenia evaluation, MDS, MDS/MPN) **(DNA)** |  | *BCR::ABL* (CML/ALL diagnosis) **(RNA)** |  |
| Other *(Provide clinical question/differential/diagnosis below)* |  | *BCR::ABL* MRD **(RNA)** |  |
| Lymphoid NGS panel options: | AML MRD: inv(16) *CBFB::MYH11* **(RNA)** |  |
| Lymphoid panel (e.g. ALL, DLBCL, other, includes *TP53*) **(DNA)** |  | AML MRD: t(8;21) *RUNX1::RUNX1T1* **(RNA)** |  |
| CLL (including TP53 mutations and IGHV SHM) **(DNA/RNA)** |  | APML MRD: t(15;17) *PML::RARA* **(RNA)** |  |
| *TP53* mutations only (for CLL or MCL) **(DNA)** |  | AML MRD: *NPM1* **(RNA)** |  |
| T-NHL evaluation **(DNA)** |  | MLL MRD: t(9;11) *KMT2A::MLLT3* **(DNA)** |  |
| LPL/WM (including MYD88) **(DNA)** |  | MLL MRD: t(11;19) *KMT2A::MLLT1* **(DNA)** |  |
| HCL (BRAF) **(DNA)** |  | MLL MRD: t(10;11) *KMT2A::MLLT10* **(DNA)** |  |
| Other(*Provide clinical question/differential/diagnosis below*) |  | ALL MRD – please specify B or T **(DNA/RNA)** |  |
| Haem Onc SNP Array: |  | ALL TPMT/NUDT15 **(DNA)** |  |
| New Diagnosis Paediatric ALL **(DNA/RNA store)** |  | *FIP1L1::PDGFRA* MRD **(DNA/RNA)** |  |
| Other **(DNA)** |  | Other – please provide details below |  |
| RNA Fusion Panel |  | **Please note – New diagnosis AML, MPN screening (MPN and *BCR::ABL*) and diagnostic/follow up ALL testing require RNA and DNA extractions – please send at least two EDTA tubes.** |
| Pan-Haem (Myeloid/ALL/histiocytosis) **(RNA/DNA store)** |  |
| **Clinical Details**  |
| **Sample Type:** | **Pathology block/sample no. (if applicable):**  |
| **High Infection Risk?** | [ ]  | Yes | [ ]  | No | **Sample Date:** | Select Date from Calendar | **Taken by:** | Enter Full Name |
| North West Genomic Laboratory Hub – Manchester SiteManchester Centre for Genomic MedicineSample Reception (6th Floor)St Mary’s HospitalOxford RoadManchester M13 9WL | Tel: 0161 276 6122Email: mft.genomics@nhs.net |
| **Guidance Notes – Molecular Genomic Testing Request Form – HAEMATO-ONCOLOGY** |
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| **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 and bone marrow can be sent for all tests. FFPE tissue can be sent for T and B cell clonality and Lymphoid NGS panel. Peripheral blood and bone marrow samples should reach the laboratory within 48 hours of being taken for MRD tests. For FFPE samples the tissue type should be specified. **Sample Volume:** For MRD testing please provide at least 4-10mL peripheral blood and/or 3mL of bone marrow.For other tests please provide 2-3mL bone marrow, 4mL peripheral blood. For FFPE samples, please send 2 tubes of 5 x 10µM sections specifying the pathology block number on the tubes as well as on the form.**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.

Other details should be completed as fully as possible: * **E-mail/Tel**; without an email/telephone number, urgent results cannot be given. Reports will only be sent by first class post.

**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** |