



GENETICS LABORATORIES TEST REQUEST

North West
NHS Genomic Laboratory Hub

Please PRINT clearly in black ball point pen as this form will be scanned

Surname:		Date of Birth:		Genetics Laboratory ID:		
First name:		Birth Gender:		FOR GENETICS		
NHS number:		Hospital No:		Date/time received:		
Hospital:		G Number:		LABORATORY		
Home Address:		NHS Private		Sample type/volume:		
		Postcode:		USE ONLY		
Referring clinician: (PRINT SURNAME)		Signature:		First sample review:		
				Sample collection:		
Dept / Surgery:		Contact Tel number:		Time:		Signature:
E-mail address:		Fax No:		Date:		
TEST REQUIRED (see overleaf for sample requirements)				SAMPLE TYPE		
☐ DNA Storage EDTA	□ FISH		☐ Amniotic	☐ Amniotic Fluid (AF)		☐ Blood EDTA
☐ Microarray EDTA	☐ Karyotyping		☐ Blood Lith Hep			☐ Bone Marrow
☐ Gene/panel test EDTA	☐ Fixed cell Storage Lith Hep		☐ Buccal Scr	☐ Buccal Scrape/Saliva sampl		☐ Solid Tumour
Please Specify below		☐ Chorionic Villus		Sample (CVS) 🗆 Urine	
REASON FOR GENE/PANEL TEST			☐ Solid Tissu	□ Solid Tissue (specify origin)		
			□ Other			
☐ Mutation Screen / Diagno	HIGH RISK SAMPLES:					
Mutation Screen / Diagnostic TestPredictive Test (asymptomatic)			If a specimen is known to present an infection hazard it must be clearly labeled 'DANGER OF INFECTION' and the			
☐ Carrier Test (recessive disorder)			infection hazard stated			
☐ Family studies		VIRAL HEPAT			YES NO	
Other			OTHER HIGH RISK INFECTION YES NO Please Specify:			
<u>.</u>						ACT INFORMATION
Disease / Clinical Details - Please give clinical details and full family history (if any). If pregnant please indicate gestation in section below.					Tel: 0151 702 4228 / 4229	
(ii any). If pregnant please indicate gestation in section below.					Fax: 0151 702 4230	
					www.liverpoolwomens.nhs.uk	
					generic email: (monitored daily) dna.liverpool@nhs.net	
					Oncology section specific email: mft.genetics-oncology@nhs.net	
					PLEASE DELIVER TO:	
					North West Genomic Laboratory Hub (LIVERPOOL)	
					Manchester Centre for Genomic	
					Medicine,	
Consent to store (see overleaf)				Liverpool Women's Hospital,		
Please tick if patient does NOT want any remaining DNA/RNA or fixed cell suspensions stored in the laboratory					Crown Street,	
<u> </u>					Liverpool, L8 7SS	
GRAVIDA: PARA: Partner name: Partner name:						OB:

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Please note this section of the referral card is for your reference, and is not required to be sent as part of the referring documentation.

DO NOT FIX OR FREEZE SPECIMENS. WHERE APPROPRIATE, KEEP IN A REFRIGERATOR OVERNIGHT OR AT THE WEEKEND. SEND SAMPLES AT ROOM TEMPERATURE IN APPROPRIATE PACKAGING BY 1st CLASS POST OR INTERNAL COURIER.

SAMPLE REQUIREMENTS

(Lithium heparin bottles have the GREEN or ORANGE top and EDTA bottles have PINK or PURPLE tops)

Molecular Genetic (gene based) Testing

BLOOD SAMPLE – EDTA 3mls adults; 1-2ml from young children. In **EDTA** blood collection tube – MIX WELL and store at 4°C. DO NOT FREEZE

SALIVA SAMPLE – Saliva is a useful alternative to blood samples for certain tests. Samples must be collected in an approved kit (please contact the laboratory for further information)

OTHER TISSUE – By arrangement with the laboratory.

Cytogenetic (chromosome based) Testing

Postnatal blood Referrals: 1-2 ml for new born infants, 5 ml for older children and Adults

For Karyotype / FISH analysis: LITHIUM HEPARIN collection tubes – MIX WELL and store at 4°C. DO NOT FREEZE

For Microarray analysis: EDTA collection tubes – MIX WELL and store at 4°C. DO NOT FREEZE

Amniotic Fluid samples: Karyotype or microarray analysis: 15-20 ml in a sterile container.

Chorionic Villus samples (CVS): Send in transport media, provided by the laboratory on request.

Karyotype analysis only: 7-10 mg. Karyotype & single gene testing: 10-15 mg. Microarray analysis: 20 mg.

For Biochemical assays: >20mg.

Solid Tissues samples: send in **transport media**, provided by the laboratory on request.

If solid tissue transport media unavailable please send in STERILE SALINE solution.

** Formaldehyde or any fixative solution is unsuitable where culturing is required**

Oncology Cytogenetic Referrals:

Bone Marrow samples 1-2- ml of aspirate in 5ml **transport media**, provided by the laboratory on request. If no transport media available please send in <u>LITHIUM HEPARIN</u> tubes.

Blood samples for CLL, CML referrals: in EDTA or LITHIUM HEPARIN tubes.

Lymph Nodes, send in **transport media**, provided by the laboratory on request.

Formalin fixed Paraffin Embedded Tissue (FFPEs), 4-5 microns (with H&E slide, clearly highlighting area of interest) Touch Preps.

Consent

It is the responsibility of the referring clinician to ensure that consent has been obtained for the tests requested.

The laboratory stores any remaining DNA/RNA and fixed cell suspensions (6 months) on all samples received for the following purposes: Audit, Education & Training and Quality Assurance.

Consent is not required for these purposes but it is good practice to make the patient aware of this Policy.

Please contact the laboratory if you wish to discuss this policy further.

For a more in depth information regarding referrals and reporting times please visit the genetics service website: http://www.liverpoolwomens.nhs.uk/Health Professionals/Genetic Laboratory Services.aspx

For information on how to package samples for safe transportation please look at the following website: https://www.liverpoolwomens.nhs.uk/media/3261/genetics_laboratory_user_leaflet.pdf