Genetic Testing Request Form – V8

North West Genomic Laboratory Hub (NW GLH) Manchester, Manchester Centre for Genomic Medicine (MCGM)

UKAS MEDICAL 9865

Patient Details	Payment Status: ☐ NHS ☐ Private	Referring Clinician
Surname:		Consultant (in full):
Forename:		Hospital (in full):
DoB:	NHS No:	Department: / Tel:
Sex:	Hospital No:	Midwife: / Email:
Address: Postcode:		Copy report to (if applicable):
Fetal Gestation:	Ethnic Origin (CF only):	Consent Statement – It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample may be stored. Referring Clinician Signature:

Sample Information	Test Requested	Clinical Indications & Test Details
High Infection Risk? ☐ Yes ☐ No	☐ Storage (Fixed Cell Suspension)	
Date Taken:	☐ Karyotyping ☐ FISH ☐ Rapid Aneuploidy	
Blood Tube Requirements: Li-HEP Tube / EDTA Tube	☐ Microarray (Include Clinical Indications) ☐ Diagnostic Screen/Test ☐ Predictive/Pre-symptomatic Test ☐ Prenatal ☐ Carrier Test	
Sample Type: - Fetal blood, specify if cord or cardiac sample - Fetal tissue, include delivery date & gestation - Solid tissue, specify sub type & anatomic site	☐ *DNA STORAGE ONLY, NO TESTING* *(Tick this box ONLY)*	- Include Down Syndrome Risk Screening for prenatal samples - Include pedigree, details of familial variant, name and DoB of proband if relevant - If for external testing please use our Export Request Form - If test is invoiceable, please provide a non-identifiable patient reference or purchase order no.
Sample Taken By:		Guidance notes shown over page, further details can be found at ManGen.org.uk

NW GLH Manchester use ONLY

Date:	Duty Scientist:	Lab Barcode
Routine Fast Track Urgent	High Risk: Yes No Not stated	
DNA database test code:	iGene test indication:	
Duty Scientist comments (with date and initials):		

DNA extraction: Yes No RNA	Cell culture: Yes No	Return to pre-analytical: Yes No	
Sample condition (extraction):	Sample condition (culture):		
Blood: EDTA Li-Hep Blood spot Other:	Blood: Li-Hep EDTA	Other:	
No. tubes: <1ml: Y / N Spare: Y / N	Culture: standard w/o NSU	Setup:	Check:
DNA vol.: µl mouth wash mouth swab	Prenatal: AF CV Other	AR aliquot:	Check:
Prenatal: AF CV cultured cells	AF cultures: 2 4 None	Setup:	Check:
Fresh tissue type:	CV: cyto backup export	Sorted:	Check:
Fixed tissue Path #:	Transport media #:	Weight:	Check:
wax block unstained slides:	If sent away, amount:	Setup:	Check:
shavings: stained slides: marked: Y / N	Tissue type:		
cutting (operator): cutting (checker):	TC cultures	Setup:	Check:
Chemagen COBAS (specify):	QF-PCR: 13,18,21 X&Y No	Taken:	Check:
iGENatal EZ1 (specify):	Confirmatory QF-PCR:	Taken:	Check:
Technical comments (with date and initials):	Previous linked sample numbers:		
Tech (check): Tech (transfer):			

Manchester University NHS Foundation Trust

North West NHS Genomic Laboratory Hub

UKAS MEDICAL 9865

North West Genomic Laboratory Hub (GLH) Manchester
Manchester Centre for Genomic Medicine (MCGM)
6th Floor, Saint Mary's Hospital,
Oxford Road, Manchester, M13 9WL

GLH Operations Scientific Director:
Dr A Wallace PhD FRCPath
Email: andrew.wallace@mft.nhs.uk
Telephone: 0161 701 4919

Guidance Notes – Genetic Testing Request Form – V8

Patient Details

The following are details are mandatory, other details should be completed fully as possible:

- **Surname** & **Forename**
- **DoB** – Date of Birth
- **NHS Number** (10 digits)
- Patient **Sex**
- First line of **Address** & **Postcode**

Payment Status: private patients should be declared with full billing details to ensure the sample is accepted and processed.

Sample Information

High Infection Risk: In accordance with the Health & Safety at Work Act and the 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.

Prenatal Samples – Store overnight at 4°C if required, DO NOT freeze or expose to heat. The sample must arrive in laboratory within 24 hours of being taken.

- **Amniotic Fluid**: 10-20ml in sterile leak proof plastic universal.
- **Chorionic Villi**: 10-30mg in sterile transport media. See guidance on website for further information
- **Fetal Blood**: 1ml in a 2ml paediatric **Lithium Heparin** tube, mix well to prevent clotting.

Postnatal Samples – Store overnight at 4°C if required, DO NOT freeze or expose to heat. The sample must arrive in laboratory within 48 hours of being taken.

- **Venous Blood**: use Lithium Heparin (Li-HEP) tube only:
  - 4ml for adults and children
  - 1ml minimum for neonates
- **Solid Tissue:** DO NOT expose to formalin. Send in dry sterile plastic container (or if stored overnight in sterile saline).

Store sample at 4°C if required, send by courier or first class post.

- **Venous Blood**: use EDTA tube only:
  - 4ml for adults and children (BD Vacutainer preferred)
  - 1ml minimum for neonates (Sarstedt Micro Tube preferred)
  - 10-16ml for Free Fetal Sexing, must be received in the Lab within 24 hours of blood being taken (BD Vacutainers)
- **Mouthwash Samples**: GeneFiX or Oragene collection kits only
- **Other Sample Types:** by prior arrangement only.

Tissue Type: If solid tissue the type should be specified, for fetal tissue samples the date of delivery and gestation must be included. Fetuses cannot be accepted under any circumstances.

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

The following details are mandatory:

- **Consultant** name is mandatory, initials are not acceptable as the laboratory cannot identify the consultant. A minimum of first initials and surname in full must be provided.
- **Hospital** should be clearly identifiable, initials are not acceptable as the laboratory can not 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 can not identify the department.
- **Midwife** is only applicable to prenatal referrals.

Other details should be completed fully as possible:

- **Tel/email**, without a telephone/email urgent results cannot be given, reports will only be sent by first class post.
- **Copy report to** is optional, if more space is required please use the Clinical Indications & Test Details box.

Consent Statement must be signed for the sample to be accepted and processed by the laboratory.

Test Requested

More than one test can be requested when relevant to the investigation, ensuring the appropriate sample type(s) are supplied for the requested test(s).

Full details of the Clinical Indications and Test/Gene Variant must be supplied to ensure the correct test/analysis is performed.

Clinical Indications & Test Details

Illegible forms will result in delays to testing and reporting.

As much detail as possible should be provided, if required additional reports and letters can be attached to this referral form.

NW GLH Manchester Contact Details

Laboratory Opening Hours: 09:00 – 17:00, Monday to Friday

Telephone: 0161 276 6553 | **Telephone:** 0161 276 6122

For general enquiries email: mft.genomics@nhs.net

DO NOT email patient, personal identifiable, confidential or sensitive information to the NW GLH Manchester site without secure encryption.

Website: www.ManGen.org.uk

Delivery Address

Laboratory Sample Reception,
6th Floor, Saint Mary's Hospital,
Oxford Road, Manchester,
M13 9WL, United Kingdom

DO NOT SAVE OR PHOTOCOPY – Current forms can be printed from www.ManGen.org.uk/useful-forms – DO NOT SAVE OR PHOTOCOPY