Oxford Regional Genetics Laboratories
Oxford University Hospitals NHS Foundation Trust
The Churchill Hospital

Oxford OX3 7LE

Patient Details

NHS No:

Surname:

Forename:

Admin office: 01865 226001

Email: dutyscientist.oxfordgenetics@ouh.nhs.uk



Oxford Genetics Laboratories

Familial Hypercholesterolaemia (R134) Genetic Testing Request Form

Sex:

Address:

Date of Birth:				Postcode:		
Hospital:				Hospital No:		
Ethnicity:						
Requester Details						
Clinician:				Email:		
Reporting	_			Invoice		
Address:				Address:		
Clinical Info	rmation	Τ.		·	T	
CVD History	T .	Age	Clinical signs o	† FH	Lipids	
ACS/MI			Corneal arcus		Currently on statins?	
CABG			Xanthelasma		Dose:	
PTCA			Tendon xantho	oma	Pretreatment levels:	
Angina					Total cholesterol:	
Stroke/TIA					LDL-c	
PVD					HDL-c	
Cartoid artery intima-media thic		ia thickness:			Triglycerides	
Other:						T
Referral criteria used: Simon Bro			me: Welsh: Dutch: Oth		ther:	Score:
Family history of CVD,						
raised cholesterol etc.						
Testing required						
Diagnostic testing						
Full sequence analysis of LDLR, APOB, PCSK9, LDLRAP1, APOE						
Dosage analysis of LDLR						
Polygenic LDL-C-raising SNP score						
Please note dosage analysis may be less reliable on DNA from buccal						
swabs. Blood is the preferred tissue type for this analysis.						
Familial variant testing						
Testing for a known familial variant for either:						
 Cascade testing of a pathogenic variant 					Affected:	Unaffected:
Segregation analysis of a variant of uncertain significance					Affected patien	its only
Index case name:						
Index case date of birth:						
Relationship to the patient:						
Please provide a copy of the relative's diagnostic genetic report or as						
much information as possible regarding where and when testing was						
carried out including the variant if known						
					L	

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Website: www.ouh.nhs.uk/geneticslab
Telephone: 01865 226 022