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| Genomic Medicine Service Whole Genome Sequencing (WGS) Test Request PLEASE DO NOT USE FOR NON-WGS TESTS | <div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;">CANCER</div> |  |
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| Requesting organisation: | |
| GLH laboratory to receive sample: | Test Required Whole Genome Sequencing |

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|--|---|
| Patient first name | Ethnicity |
| Patient last name | Test Directory Clinical Indication & code (cancer type & sub-type) |
| Date of birth <small>(dd/mm/yyyy)</small> Hospital number | |
| Gender Male Female Other | Presentation status First diagnosis Recurrence / Relapse Unknown |
| Postcode <input style="width: 100px;" type="text"/> | Additional clinical information (if required) <i>E.g. previous tumours, molecular testing, and relevant treatment history with date(s)</i> |
| NHS number <input style="width: 100px;" type="text"/> | |
| Reason NHS Number not available: Patient not eligible for NHS number (e.g. foreign national) Other (provide reason): | |

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| Solid tumour requests only | | | |
| Primary Metastatic Unknown Lymphoma | Histopathology Lab ID | Additional tumour information (if relevant) <i>E.g. site of metastasis (if metastatic), or unknown primary</i> | |
| | Date of this diagnosis <small>(dd/mm/yyyy)</small> | Tumour topography | Tumour morphology |

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| Haemato-oncology liquid tumour requests only | | | |
| AML ALL Other (please specify): | SIHMDS Lab ID | Date of this diagnosis <small>(dd/mm/yyyy)</small> | |

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| Complete for tumour samples (being sent to GLH DNA extraction lab) | | | |
| Fresh frozen tumour Bone marrow Blood (EDTA) Other (please specify): | | | |
| % malignant nuclei / blasts or equivalent in this sample (refer to sample handling guidance) must be provided below | | | |
| Sample ID | Collection date / time | % Malignant nuclei / blasts | If BM/PB provide volume and nucleated cell count |

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|---|------------------------|-----------------------------|----------|
| Complete for germline samples (being sent to GLH DNA extraction lab) | | | |
| Blood (EDTA) Saliva Fibroblasts Skin biopsy Other (please specify): | | | |
| Sample ID | Collection date / time | Sample volume if applicable | Comments |

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| Responsible consultant | Main contact (if different from responsible consultant) |
| Name: | Name: |
| Department address: | Department address: |
| Phone: | Phone: |
| Email: | Email: |

I have attached a copy of the Record of Discussion form
 Patient conversation taken place; Record of Discussion form to follow