

<u>PATIENT DETAILS</u> <i>(Printed label if available)</i>	<u>REFERRER DETAILS</u>
Family name:	Consultant / Clinician: Job Title:
First name(s):	Hospital address:
Date of birth:	
NHS number: Sex: M F U	
Hospital number:	Email: Tel No:
Address: Ethnic Origin:	(PTO for more information)
Case / Family number:	Contact Name: (if different)
Postcode: NHS Private <small style="margin-left: 100px;">Please supply the name and address for invoicing</small>	Additional copies to:

CLINICAL DETAILS AND FAMILY HISTORY

For pedigrees please mark ♂ against person sampled with this request card. Where appropriate identify other family members that may be known to the lab with their full name and date of birth.

Is the patient or their partner pregnant?	If YES: gestation at sampling by scan?	Patient wishes to know fetal sex?
---	--	-----------------------------------

For infertility referrals please give partner's name and DOB:

If this case has been discussed with the Clinical Genetics department, please give name of contact in Genetics:

HIGH RISK SAMPLES: If a specimen is known to present an infection hazard it must be clearly labelled 'DANGER OF INFECTION' and the infection hazard stated.

Sample requirements – further details available from our web-site: www.ouh.nhs.uk/geneticslab

For Chromosome analysis, Fluorescence in situ hybridization (FISH): **Blood in LITHIUM HEPARIN (1-5ml)** (Tick box if requested)

For Gene sequencing, specific mutation tests, dosage, array CGH: **Blood in EDTA (1-5ml)** (Tick box if requested)
N.B. For FRAX testing please send blood in both EDTA and lithium heparin

Prenatal sample (please circle) **Amniotic fluid / CVS / Fetal blood** Volume (if appropriate) ml
N.B. If molecular testing is requested, a maternal blood sample in EDTA should also be sent.

Has this patient had a recent blood transfusion or ever had a bone marrow transplant? Yes / No – if yes give details below

Other (Please state) **Date sample taken:**
Name of person taking sample:

TEST(S) REQUESTED – please read consent information overleaf

NHSE Genomic Medicine Service R/M Code:

For Lab Use

Date of receipt: Initials: Sample Condition/Volume:
 Comments:

CONSENT:

In submitting this sample the clinician confirms that informed consent has been obtained for (a) storage and testing (current and future testing as this becomes available) (b) the use of this sample and the information generated from it to be shared with members of the donor's family and their health professionals (if appropriate).

If specific consent to any of the above is not given please provide details below.

The patient should be advised that the sample may be used anonymously for quality assurance, training and research purposes.

Further Information:

In complying with the Human Tissue Act 2004 all surplus tissue samples are discarded once DNA/RNA has been extracted.

Please be aware that anonymised genomic and clinical data may be shared within and beyond the NHS for diagnostic and research purposes.

Electronic Reporting via Email:

The Oxford Genetics Laboratories are now offering the option to receive reports by Email. If you would like to receive future reports via this method please provide your email address in the referrer details section (NHS.net email preferred). To set this up, the laboratory will contact you with further information.

Laboratory contact details:

General Enquiries Tel: +44 (0)1865 226001

Duty scientist e-mail: orh-tr.dutyscientist.oxfordgen@nhs.net

Opening hours: 9.00am – 5.00pm Monday – Friday (excluding bank holidays)

Sample dispatch:

Send samples at room temperature by 1st class post or courier to:
(For other samples please enquire or consult web-site)

**Oxford Regional Genetics Laboratories
Churchill Hospital
Old Road
Headington
Oxford
OX3 7LE
UK**

N.B. Samples for chromosome analysis should be sent to arrive at the laboratory within 24 hours.

For further information about sample requirements and tests available see:

www.ouh.nhs.uk/geneticslab