

Willink Unit, Genetic Medicine, 6 th Floor, Pod 1, St Mary's Hospital Oxford Road, Manchester M13 9WL		Phone 0161 70 12137 Fax 0161 70 12303 email: forename.surname@cmft.nhs.uk	Central Manchester University Hospitals NHS Foundation Trust	NHS
WILLINK NUMBER		REFERRING LAB NUMBER	HOSPITAL / NHS NUMBER	
SURNAME		HOSPITAL	WARD	
FORENAMES		REQUESTING DOCTOR (print and sign)		
DATE OF BIRTH	REFERRING LABORATORY (address for reports)			
SEX M / F				
CONSULTANT (name and phone number)		SPECIMEN	DATE AND TIME OF COLLECTION	
PRIORITY STATUS: URGENT _____ ROUTINE _____	CLINICAL DETAILS (including drugs)			
TEST(S) REQUIRED (please tick)				
<input type="checkbox"/>	URINE:	<input type="checkbox"/>	BLOOD:	
<input type="checkbox"/>	AMINO ACIDS SCREEN (TLC)	<input type="checkbox"/>	QUANTITATIVE AMINO ACIDS	
<input type="checkbox"/>	ORGANIC ACIDS	<input type="checkbox"/>	LYSOSOMAL ENZYME SCREEN	
<input type="checkbox"/>	MUCOPOLYSACCHARIDES	<input type="checkbox"/>	OTHER LYSOSOMAL ENZYME (specify below)	
<input type="checkbox"/>	OLIGOSACCHARIDES	<input type="checkbox"/>	VERY LONG CHAIN FATTY ACIDS	
<input type="checkbox"/>		<input type="checkbox"/>	CARNITINE/ACYLCARNITINE	
<input type="checkbox"/>	OTHER INVESTIGATIONS (specify below)	<input type="checkbox"/>	MITOCHONDRIAL DNA (specify below)	
<p>A full list of analyses offered and specimens required is detailed in the Laboratory User's Handbook: www.mangen.co.uk Responsibility for consent required for these genetic tests remains with the referring clinician.</p>				
DATE SPECIMEN RECEIVED:		TIME SPECIMEN RECEIVED:		