

Genetic Medicine GENETIC TEST REQUEST

Surname: <input style="width: 90%;" type="text"/>		Forename(s): <input style="width: 90%;" type="text"/>		Date received: <input style="width: 80%;" type="text"/>	
Date of birth: <input style="width: 80%;" type="text"/>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	NHS No: <input style="width: 80%;" type="text"/>	Hospital No: <input style="width: 80%;" type="text"/>		
Address: <input style="width: 95%;" type="text"/> Postcode: <input style="width: 60%;" type="text"/>		Ethnic origin (CF only): <input style="width: 80%;" type="text"/>		Payment: <input type="checkbox"/> NHS <input type="checkbox"/> Private	
		Consultant (surname in full): <input style="width: 95%;" type="text"/>			
Reason for request / Clinical Indication: <small>- Include pedigree & details of familial mutation if relevant. - If risk of Down Syndrome from Serum Screening, then please give risk figure - ALL forms can be downloaded from www.mangen.org.uk</small>		Hospital (in full): <input style="width: 95%;" type="text"/>		Dept: <input style="width: 80%;" type="text"/>	
		Tel: <input style="width: 80%;" type="text"/>		Fax: <input style="width: 80%;" type="text"/>	
		Midwife (if applicable): <input style="width: 80%;" type="text"/>		Copy report to (surname in full—if applicable): <input style="width: 95%;" type="text"/>	
		<p>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 for future diagnostic tests.</p> <p>Referring clinician signature: <input style="width: 95%;" type="text"/></p>			

PLEASE COMPLETE THE SECTION BELOW: MORE THAN ONE TEST CAN BE REQUESTED

<input type="checkbox"/> High infection risk? Please ring lab first	Date sample taken: <input style="width: 80%;" type="text"/>	Gestation (prenatal ONLY): <input style="width: 80%;" type="text"/>	Date of delivery (fetal tissues ONLY): <input style="width: 80%;" type="text"/>
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<p>TEST TYPE</p> <input type="checkbox"/> Rapid aneuploidy <input type="checkbox"/> Karyotyping <input type="checkbox"/> FISH <input type="checkbox"/> Storage <p style="text-align: right; font-weight: bold;">CHROMOSOMES</p>	<p>SAMPLE TYPE (Please tick appropriate box(es))</p> <input type="checkbox"/> Blood <input type="checkbox"/> Fetal Blood <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> CVS <input type="checkbox"/> Solid tissue (specify origin)→ <input style="width: 80%;" type="text"/> <p style="text-align: right; background-color: red; color: white; padding: 2px;">Use Li-HEP tube for blood</p>	<p>TEST(S) REQUESTED / SPECIFIED</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
<p>TEST TYPE</p> <input type="checkbox"/> Mutation screen / Diagnostic test <input type="checkbox"/> Predictive / Presymptomatic test <input type="checkbox"/> Prenatal <input type="checkbox"/> Carrier test <input type="checkbox"/> Storage <input type="checkbox"/> Export (include EXPORT form—see below) <p style="text-align: right; font-weight: bold;">GENES (DNA)</p>	<p>SAMPLE TYPE (Please tick appropriate box(es))</p> <input type="checkbox"/> Blood <input type="checkbox"/> DNA <input type="checkbox"/> Mouthwash <input type="checkbox"/> Solid tissue (specify origin)→ <input style="width: 80%;" type="text"/> <p style="text-align: right; background-color: red; color: white; padding: 2px;">Use EDTA tube for blood</p> <p style="text-align: center;">SEE BELOW FOR <u>DETAILED</u> SAMPLE REQUIREMENTS</p>	



DELIVERY ADDRESS:

Genetic Medicine
6th Floor, St Mary's Hospital
Oxford Road
Manchester
M13 9WL
UNITED KINGDOM

Bar-code label / Lab No.

Date received:

SERVICE INFORMATION

For detailed lab and referral information, please see our website:

www.mangen.org.uk

Our lab opening hours are:

09:00—17:00 Monday to Friday

CHROMOSOME ANALYSES

CONTACT INFORMATION (CYTOGENETICS LAB)
 General Enquiries—0161 276 6553 / 6118 Head of Lab—0161 276 6553
 Fax—0161 276 6238 Quality Manager—0161 276 6741

SAMPLES REQUIRED
 Prenatal samples—DO NOT freeze or expose to heat. Must arrive in lab within 24 hours.
 Amniotic fluid—10-20ml in sterile leak-proof plastic container
 Chorionic villi—10-30mg in sterile transport media. See guidance on website.
 Fetal blood—1ml in a 2ml paediatric **Lithium Heparin** tube (mix well to avoid clotting).
 Postnatal samples—DO NOT freeze or expose to heat. Can be stored overnight at 4°C if required.
 Venous blood—use **Lithium Heparin** tube ONLY. 5ml adults / children, 1ml minimum for neonates. Send within 48 hrs of venepuncture.
 Solid tissue—DO NOT expose to formalin. Send in dry sterile plastic container (or sterile saline if stored overnight)

GENE (DNA) ANALYSES

CONTACT INFORMATION (DNA LAB)
 General Enquiries—0161 276 6122 Head of Lab—0161 276 8004
 Fax—0161 276 6606 Quality Manager—0161 276 6741

SAMPLES REQUIRED
 Blood samples—use **EDTA** tube ONLY. Adults / children (5ml required). Neonates (1ml minimum)
 Mouthwash samples—in Oragene container ONLY (available from the lab).
 Other samples—by prior arrangement ONLY.
 Storage—at 4°C and send by first class post.

EXPORT OF SAMPLES (for testing in another lab)
 Any samples for tests not listed or shown as services on our website (see www.mangen.org.uk) must be accompanied by a completed sample export form. Sample export forms can be downloaded from our service website. The laboratory Duty Scientist (0161 276 6122) is happy to assist with sample export enquiries.

PACKAGING

The sample and referral card should be sealed separately in a biohazard bag to prevent contamination of paperwork in the event of leakage. **All packaging should conform to UN650 standards.**

HIGH RISK SAMPLES

The sender has the responsibility for minimizing the risk to laboratory staff by giving sufficient information to enable them to take appropriate safety precautions when testing a specimen. **If a specimen is known to present an infection hazard, it must be clearly labelled "Danger of infection".**