CPA
Accredited Medical Laboratory
Reference No 2010, 2390

North East Thames Regional Genetics Service Laboratory

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

GENETIC TEST REQUEST FORM

SURNAME		FIRST NAME
DATE OF BIRTH	GENETIC ID	NHS NUMBER
SEX	ETHNIC ORIGIN	HOSPITAL NUMBER
PATIENT ADDRESS & POSTCODE		
GP NAME & ADDRESS		NHS / PRIVATE
		PCT CODE
REFERRING CONSULTANT		
ADDRESS FOR REPORT		CONTACT NUMBER

LAB REF.	
SAMPLE TYPE	URGENT / ROUTINE
DATE / TIME COLLECTED	DATE / TIME RECEIVED

REASON FOR REFERRAL
Please give clinical details

☐ **MOLECULAR GENETIC TEST** (EDTA):
Specify disease / gene test(s) and provide any relevant family history:

☐ DNA STORAGE *ONLY*
☐ DIAGNOSTIC TEST
☐ CARRIER TEST
☐ PREDICTIVE TEST

☐ **MICROARRAY** (EDTA & LITHIUM HEPARIN): Please confirm patient has one of the following:

☐ Developmental Delay ☐ Dysmorphism ☐ Multiple congenital abnormalities ☐ Epilepsy

Please provide full clinical details including family history above.

☐ **MICROARRAY FAMILY FOLLOW UP** (EDTA & LITHIUM HEPARIN)
Please give name and laboratory number of index patient.

☐ **KARYOTYPING** (LITHIUM HEPARIN)

☐ Mosaicism suspected? please give details.

Rapid testing (LITHIUM HEPARIN) (infants under 3 months) for:

☐ Trisomy 21
☐ Trisomy 13 ☐ Trisomy 18
☐ Chromosomal sex
Please also select microarray or karyotype.

In submitting the sample the clinician confirms that consent for testing and possible storage has been obtained

INSTRUCTIONS:

The sample tube and referral card must have three matching identifiers to be accepted.
Patient's gender must be indicated on the request form.

BLOOD SAMPLES: Mix samples thoroughly for 2 minutes to prevent clotting
5mls venous blood in plastic EDTA (pink) bottles (>1ml from neonates)
2mls venous blood in plastic Lithium Heparin (orange or green) bottles (1-2ml from neonates)
Lithium Heparin blood samples must be received in lab within 24 hours (refrigerate overnight 4^{o}C if necessary).
For free fetal (NIPD) analysis please send 20ml blood (EDTA) – Contact lab in advance

ANY OTHER SAMPLE eg. Prenatal, Mouthwash – TELEPHONE FOR ADVICE

Sample must be labelled with:
- Patient's full name (surname and given name)
- Date of birth and NHS number
- Referring Hospital Number
- It is desirable to have the date and time sample was taken and/or location

NOTE: **Samples in glass bottles will not be accepted**
UNLABELLED Samples will not be accepted
MISLABELLED Samples will result in delay

Samples coming from outside Great Ormond Street Hospital / Institute of Child Health MUST BE PACKAGED IN ACCORDANCE WITH **UN PACKING REQUIREMENT PI 650** and clearly labelled **'diagnostic specimen UN3373'**

Send by first class post or courier to this address:
Specimen Reception
Level 5, York House
Great Ormond Street Hospital
37 Queen Square
London WC1N 3BH
Tel: 020 7829 8870 Fax: 020 7813 8578

For details of all referral criteria and policies please see our website:
www.labs.gosh.nhs.uk/laboratory-services/genetics

For Lab Use Only