

# CANCER GENETICS REFERRAL FORM - LIQUID SAMPLES

<b><u>Patient Details</u></b> Surname: Forename:  DOB: Sex: M / F  Hospital Number:  NHS Number:		<b><u>Referring Hospital</u></b> Hospital:  Consultant:  e-mail address:  Signed:	
<b><u>Clinical details/reason for referral:</u></b>   <input type="checkbox"/> <b>Urgent</b> <input type="checkbox"/> <b>Routine</b> <b><u>If urgent, please state why and give date if applicable</u></b>		<b><u>Sample type:</u></b>  <input type="checkbox"/> <b>BM</b>  <input type="checkbox"/> <b>PB</b>  <input type="checkbox"/> <b>Other (specify):</b>  Date sample taken:  Time sample taken:	
<b><u>Test requested - cytogenetics</u></b>  <input type="checkbox"/> <b>Karyotype</b>  <input type="checkbox"/> <b>FISH (specify):</b>   <i>Please send PB samples in lithium heparin or bone marrow transport medium.</i> <i>All other samples in bone marrow transport medium.</i>		<b><u>Test requested - molecular</u></b>  <input type="checkbox"/> <b>PML-RARA</b> <i>Please send 20ml of PB <u>and</u> 1-5ml of BM in EDTA</i>  <input type="checkbox"/> <b>NPM1</b> <i>Please send 20ml of PB <u>and</u> 1-5ml of BM in EDTA</i>  <input type="checkbox"/> <b>BCR-ABL</b> <i>Please send 20ml of PB in EDTA</i>  <input type="checkbox"/> <b>JAK2 V617F</b> <input type="checkbox"/> <b>MPL exon 10</b> <input type="checkbox"/> <b>JAK2 exon 12</b> <input type="checkbox"/> <b>CALR</b> <i>Please send 2ml of PB in EDTA</i>	
<b><u>Address for samples</u></b>  <b>Cytogenetics:</b> Genetics, 5th Floor Tower Wing, Guy's Hospital, Great Maze Pond, London SE1 9RT Telephone: 020 7188 1709  <b>Molecular:</b> Molecular Oncology, 4 <sup>th</sup> Floor Southwark Wing, Guy's Hospital, Great Maze Pond, London SE1 9RT Telephone: 020 7188 7188 ext 51060  In submitting this sample the clinician confirms that <u>consent has been obtained</u> for testing and possible storage			
<b>Cancer Genetics</b>		Date received      Time received	

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