Laboratory Contact details
Telephone: 020 3299 2265
Telephone: 020 3299 5829
Fax: 020 3299 1035
Section Email kch-tr.PND@nhs.net

Molecular Diagnostics

Dept of Molecular Pathology
1st Floor Cheyne Wing
King's College Hospital
Denmark Hill
London SE5 9RS
www.viapath.co.uk
www.kch.nhs.uk

Request for DNA Diagnosis (please complete as much as possible)

Patient		**Referrer**		**GP Details**	
Surname		Surname		Name	
First name		First name		Surgery	
DoB		Department		Address line 1	
Sex		Address line 1		Address line 2	
Ethnicity		Address line 2		Address line 3	
Address line 1		Address line 3		Postcode	
Address line 2		Postcode		Telephone	
Address line 3		Telephone			
Postcode		E-mail			

Pathology Results (please provide as much detail as possible). Mark boxes (**x**) where appropriate

Iron Parameters		**Haematology indices**		**Liver Function Tests**	
Serum Ferritin		Hb		Serum Bilirubin	
Serum Iron		RBC		Serum Albumin	
TIBC		MCV		AST	
		MCH		ALT	
		Platelets		ALP	
		HbF %			
		HbA_2 %			
		Hb variant %			

Histology (Liver Biopsy)	**Clinical Details** Mark boxes (**x**) where appropriate
Cirrhosis: Yes ☐ No ☐	Symptomatic ☐ Event free history ☐
• Grade of Siderosis: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐	Alcohol Consumption: (Unit/Week) _____
Liver tissue Iron concentration (μg/gm dry weight)_____	Internal organ damage: Liver ☐ Pancreas ☐ Pituitary ☐ Heart ☐ Joints ☐
	Skin Pigmentation: Yes ☐ No ☐
Reason for referral/Family details	

Molecular Tests requested (please tick all that apply)

- ☐ Hb variant
- ☐ Haemoglobinopathy investigations
- ☐ Alpha thalassaemia
- ☐ Beta thalassaemia
- ☐ Pyruvate kinase gene sequencing
- ☐ Gilbert's genotyping (TA_5/TA_6/TA_7/TA_8 repeat)

Hereditary haemochromatosis (HFE)
☐ C282Y, H63D, S65C ☐ Full gene sequencing

- ☐ Alpha-1-antitrypsin genotype (S and Z alleles)
- ☐ Thrombophilia genetic screen (FVL, F2)
- ☐ Other _____

Sample requirements:	For haemoglobinopathy investigation	2 x 4 ml EDTA blood
	Children and adults (all other tests)	4 ml EDTA blood
	Infants	1 ml EDTA blood

All blood samples must be labelled with:
First name
Surname
DoB
Date of sample

PATIENT CONSENT

For all samples sent please ensure that the patient has given appropriate consent for:

1. Analysis of DNA for diagnostic purposes
2. Storage of DNA for 5 years
3. Use of anonymous DNA for use as control samples

A copy of our consent form is available upon request.