viapath

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**Date:**

**Sender details:**

**Tel:**

# AML17 Sample Form

| | |
|---|---|
| **Requesting Hospital**: | **Consultant**: |
| **Patient's Name/Initials:**<br>**Surname**<br>**First name** | **Gender** :M/F    **DOB:**<br>**Trial Number**: 17- |
| **Date of sample:** | **Disease information/status**: |

Please tick

APL ☐     Non APL/ AML ☐

Sample type: PB ☐

BM ☐

Please use this form for all samples to be sent to Guy's Hospital as part of the AML17 Trial. In case of query please contact Guy's as above, or the AML17 Trial Office on +44 (0)29 2068 7264.

AML 17 Clinical Trial