



Surname:		First name(s):		Date of Birth:	Sex: M / F
Address:		GP address:		Consultant:	
Postcode:		Postcode:		Hospital:	Department
LMP/Gestational age: <i>(for ongoing pregnancies only)</i>		Urgent: YES / NO	NHS/PP	NHS number:	Genetics number: G
				Sample type:	Date & time of collection:

CHECK BLOOD BOTTLE TYPE and PRINT CLEARLY AND LEGIBLY – incorrect tubes/illegible/incomplete request forms will delay processing		Family history / clinical information / reason for test
CYTOGENETICS CHROMOSOME ANALYSIS 4ml blood in LITHIUM HEPARIN (1ml newborns / babies)	MOLECULAR GENETICS DNA ANALYSIS 4-8ml blood in EDTA / K2E / K3E (1-2ml newborns / babies)	
<input type="checkbox"/> Routine chromosomes (karyotype) <input type="checkbox"/> FISH for <input type="checkbox"/> Other:	<input type="checkbox"/> array-CGH * <input type="checkbox"/> store DNA only State tests required:	
* ARRAY-CGH REFFERALS MUST BE ACCOMPANIED BY A "REQUEST FOR ARRAY-CGH ANALYSIS" FORM AVAILABLE ON OUR WEBSITE		

LAB USE	Cyto sample number:	DNA sample number:	EDTA:	LiHep:	Other:	Referring doctor:
	ID:	Allocated to:	Sample condition:	Date received:	Bleep / extension / phone number:	

CONSENT FOR GENETIC ANALYSIS

Please note that DNA will be stored

During the consultation we have discussed the following issues and you have agreed to the uses indicated below

- To be completed by the patient / parent / legal guardian*:** (Circle as applicable)
- A) I agree to analysis of the sample for _____ YES / NO / N/A
- B) I am happy for further diagnostic testing on the stored sample if new tests become available, without being contacted YES / NO / N/A
- C) I agree that information and results can be shared to help other family members YES / NO / N/A
- D) I agree to the sample being used anonymously for research YES / NO / N/A

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

To be completed by the doctor / counsellor*:

I have fully explained the nature of the requested test(s) to the patient / parent / legal guardian *

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

* PLEASE DELETE AS APPROPRIATE

Illegible or unclear forms and incorrect blood bottles will result in delayed processing or no tests being performed

Samples and completed referral forms should be packaged appropriately and according to UN3373 guidelines where necessary. All samples should be sent by first class post, courier, hospital transport or taxi to:

**SW Thames Cytogenetics Unit, Jenner Wing, Floor 01,
 St. George's University of London, Cranmer Terrace, London, SW17 0RE**

For further information or advice, please contact:
 Cytogenetics (chromosomes) on 020 8725 5332 or Molecular Genetics (DNA) on 020 8725 5964
 Or visit the South West Thames Regional Genetics Service website at www.southwestthamesgenetics.nhs.uk