SW THAMES REGIONAL GENETICS LABORATORY
# REQUEST FOR CHROMOSOME & DNA ANALYSIS

St George's University Hospitals NHS
NHS Foundation Trust

| Surname: | First name(s): | Date of birth: | Sex: **M/F** |
|---|---|---|---|
| Address:<br><br>Postcode: | GP Address:<br><br>GP Postcode: | Consultant:<br>Hospital: / Department:<br>Hospital number: / Genetics number: **G** | |

| LMP/Gestational age: *(for ongoing pregnancies only)* | Urgent: YES / NO | NHS / PP | NHS number: | Sample type: | Date & time of collection: |
|---|---|---|---|---|---|

**CHECK BLOOD TUBE TYPE** and **PLEASE USE CAPITAL LETTERS**
**Incorrect tubes may be discarded and illegible or incomplete request forms will delay processing**

| **CHROMOSOME ANALYSIS**<br>4ml blood in LITHIUM HEPARIN<br>(1ml newborns / babies) | **DNA / GENE ANALYSIS**<br>4-8ml blood in EDTA / K2E / K3E<br>(1-2ml newborns / babies) |
|---|---|
| ☐ Routine chromosomes (karyotype) | ☐ array-CGH * ☐ store DNA only |
| ☐ FISH for …… | State tests required: |
| …… | …… |
| ☐ Other: …… | …… |
| …… | *Please note that DNA will be stored unless requested otherwise* |

*** ARRAY-CGH REFFERALS MUST HAVE THE ADDITIONAL "REQUEST FOR ARRAY-CGH ANALYSIS" SECTION OF THIS FORM COMPLETED**

Family history / clinical information / reason for test

☐ known family mutation / abnormality? (please tick and give details)

| | | | | | |
|---|---|---|---|---|---|
| **LAB** | Date received: | Cyto sample number: | Lithium Heparin: | Sample condition: | Other: |
| **USE** | Initials: | DNA sample number: | EDTA: | Sample condition: | |

Referring doctor:
:

Bleep / extension / phone number:

## CONSENT FOR GENETIC ANALYSIS

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
B) I am happy for further diagnostic testing on the stored sample if new tests become available, without being contacted YES / NO
C) I agree that information and results can be shared to help other family members YES / NO
D) I agree to the sample being used anonymously for research YES / NO
E) ) I am aware that the tests may reveal unexpected information, including information about a child's biological parents YES / NO

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*

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 Regional Genetics Laboratory, Specimen Reception, Jenner Wing, Lower Ground Floor,**
**St. George's University of London, Cranmer Terrace, London, SW17 0RE**

For further information or advice, please telephone 020 8725 5332
or email swtrgl@stgeorges.nhs.uk.
More information on our services can be found at www.southwestthamesgenetics.nhs.uk

SW THAMES REGIONAL GENETICS LABORATORY

# REQUEST FOR ARRAY-CGH ANALYSIS

St George's Healthcare NHS Trust

**This section of the form must be completed fully for array CGH analysis requests in addition to completion of the "Request for Chromosome & DNA Analysis" section. Failure to do so may result in delay or failure to process the sample.**

| **Last name:** | **First name:** | **DOB** | **Sex M / F** |
|---|---|---|---|
| **Referring clinician:** | **Referring centre:** | **GEN NO.** | **DNA No.** |
| **Suspected syndrome: Please specify:** | | | |
| **Relevant family history:** | | | |

| **CLINICAL FEATURES of THIS patient** | ***Please circle / complete where applicable*** |
|---|---|
| **Developmental delay difficulties/Autism** | Mild / Moderate / Severe |
| **Learning difficulties** | Mild / Moderate / Severe |
| **Autism / behavioural problems** | Mild / Moderate / Severe |
| **Cleft Lip** | Y / N |
| **Cleft Palate** | Y / N |
| **Heart defects** | Y / N<br>If "Y", please specify: |
| **Limb Anomaly** | Upper / Lower / Hand / Foot<br>Please give details: |
| **Microcephaly** | Y / N |
| **Macrocephaly** | Y / N |
| **MRI brain anomaly** | Y / N<br>If "Y", please specify: |
| **Overgrowth** | Y / N |
| **Growth below the third centile** | Y / N |
| **Dysmorphic** | Y / N<br>If "Y", please specify: |
| **Other anomaly** | Y / N<br>If "Y", please specify: |
| **Any previous genetic tests:** | Y / N<br>If "Y", please specify: |