Outstanding care every time

SW THAMES REGIONAL GENETICS SERVICE

REQUEST FOR CHROMOSOME & DNA ANALYSIS

NHS
St George's University Hospitals
NHS Foundation Trust

Surname:	First name(s):	Date of birth:	Sex: **M/F**
Address: Postcode:	GP Address: GP Postcode:	Consultant: Hospital: / Department: 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 4ml blood in LITHIUM HEPARIN (1ml newborns / babies)	**DNA / GENE ANALYSIS** 4-8ml blood in EDTA / K2E / K3E (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)

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:

Genetics Laboratories, 5th Floor, Tower Wing, Guy's Hospital,
Great Maze Pond, London, SE1 9RT

For further information or advice, please telephone 020 7188 1696
or email gst-tr.viapathgeneticsadmin@nhs.net

More information on our services can be found at:
http://www.viapath.co.uk/departments-and-laboratories/molecular-genetics-laboratory-at-guys or
https://www.stgeorges.nhs.uk/service/specialist-medicine/clinical-genetics/

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REQUEST FOR ARRAY-CGH ANALYSIS

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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.

NHS Number: **Error! Reference source not found.**					
CLINICAL INFORMATION – for chromosome imbalance testing *Place an X in the box if statement applies to the patient.*					
1 Cognitive Development	☐ Typical				
	☐ Delay (Atypical)				
	☐ Mild (IQ 50-69; for adults mental age 9-12 yrs)				
	☐ Mod (IQ 35-49; for adults mental age 6-9 yrs)				
	☐ Severe (IQ 20-34; for adults mental age 3-6 years)				
	☐ Profound (IQ <20; for adults mental age <3 years)				
2 Specific Developmental Disorder	Speech and language ☐ Reading and spelling ☐ Arithmetic ☐ Motor Skills ☐				
3 Neurodevelopmental/Behavioral Problems	Autistic Spectrum Disorder	☐ Yes	☐ No		
	ADHD	☐ Yes	☐ No		
	Tics	☐ Yes	☐ No		
	Sleep	☐ Yes	☐ No		
	Feeding	☐ Yes	☐ No		
	Psychosis	☐ Yes	☐ No		
	Other behavioral problems	☐ Yes	☐ No		
4 Neurological Disorders	Vision ☐ Hearing ☐ Abnormal tone/involuntary movements ☐ Structural brain lesion ☐				
	Cerebral Palsy Unilateral ☐ Cerebral Palsy Bilateral ☐				
	Epilepsy ☐ Age of onset <3 months ☐ 3-24 months ☐ > 24 months ☐				
5 Growth Abnormalities	At birth Small for gestational age (<10th centile)	☐ Yes	☐ No		
	At birth Large for gestational age (>90th centile)	☐ Yes	☐ No		
	Current:				
	Tall stature (height >95th centile)	☐ Yes	☐ No		
	Short Stature (height < 5th centile)	☐ Yes	☐ No		
	Macrocephaly (>95th centile)	☐ Yes	☐ No		
	Microcephaly (<5th centile)	☐ Yes	☐ No		
6 Congenital Malformations/Dysmorphism	Heart disease (e.g. ASD, VSD)	☐ Yes	☐ No		
	Renal and Urogenital malformations	☐ Yes	☐ No		
	Brain Malformations	☐ Yes	☐ No		
	Eye malformations (e.g. anophthalmia, microphthalmia)	☐ Yes	☐ No		
	Ear malformations	☐ Yes	☐ No		
	Cleft lip ☐ Cleft palate ☐				
	Micrognathia	☐ Yes	☐ No		
	Limb abnormalities (e.g. short or long bones)	☐ Yes	☐ No		
	Digital abnormalities (e.g. syndactyly, polydactyly)	☐ Yes	☐ No		
	Facial dysmorphism e.g. hypertelorism	☐ Yes	☐ No		
7 Endocrine and metabolic conditions		☐ Yes	☐ No		
8 Cutaneous stigmata/skin lesions		☐ Yes	☐ No		
9 Hair, nail, teeth abnormalities		☐ Yes	☐ No		
10 Other Skeletal abnormalities eg scoliosis		☐ Yes	☐ No		