

# REQUESTING A GENETIC TEST

Telephone 0117 414 6168 Fax 0117 414 6464

E-mail: [nbn-tr.geneticsenquiries@nhs.net](mailto:nbn-tr.geneticsenquiries@nhs.net)

Website: [www.nbt.nhs.uk/severn-pathology/pathology-services/bristol-genetics-laboratory-bgl](http://www.nbt.nhs.uk/severn-pathology/pathology-services/bristol-genetics-laboratory-bgl)

Information required for specimens sent to the Bristol Genetics Laboratory (BGL)

## Refer to NBT Clinical Governance policy CG45 – Specimen Labelling Policy 5.2 AND 5.3

**ALL** mandatory fields (in blue type) must be completed for **ALL** patients.

**ALL** sample containers (including multiple samples from the same patient) **MUST** be labelled with **at least** the full patient name, DOB and hospital number. BGL has the right to refuse to process any unlabelled samples.

Please complete forms in black or blue ballpoint pen.

If using computer-generated labels, please ensure that they are affixed to both the top and bottom copies of the form.

Please do not affix any labels to the top right hand corner of this form; this is for laboratory use only. **Illegible writing may result in a processing delay.**

Complete patient details in print or block capitals including NHS number and postcode. A computer-generated label can be used – please affix one to the back copy too.

Consultant details and report location **MUST** be provided

Please supply mother's full name and DOB for all foetal/infant samples

This information is important for quality monitoring

Please indicate if previous testing has been done on family members

Provide relevant clinical details to enable correct testing

The staging of oncology samples is important for prognosis

Patient consent is mandatory for the storage of DNA; the form **MUST** be signed by the requesting clinician.

Please only tick the tests that are required, specifying more detailed information where indicated (e.g. 22q 11 FISH). Please ask for further information if unsure (contact details above).

Identify known or suspected inoculation risks. Transfusions may affect the outcome of genetic investigations.

**Genetics Request Form**  
MANDATORY FIELDS are indicated in blue type  
See reverse for additional information on sample requirements  
Please fill out as completely as possible

BGL is a UKAS accredited medical laboratory No.9307

Tubes/Volumes BGL FM297 V5 Active 09/04/18

For BGL use only. DO NOT affix labels here

NAME (in print or block capitals)	DOB	SEX	CG number	CONSULTANT	BILLING ADDRESS (if different to report address)	Date taken by whom
Please affix patient label here			Address for report (full address please if GP surgery)		Mother's name/DOB (important for all infant/fetal samples)	Date/time received
HOSPITAL NUMBER	NHS NUMBER	REFERRING HOSPITAL	Purchase Order no:		Date and time of next appointment	Priority <input type="checkbox"/> Urgent <input type="checkbox"/> Routine
Previous genetic investigations in family: Yes/No (please give brief details below (include laboratory numbers))		For LEUKAEMIC samples please indicate: Diagnostic <input type="checkbox"/> Follow-up (Remission) <input type="checkbox"/> Follow-up (Relapse) <input type="checkbox"/> Bone marrow transplant, specify sex of donor <input type="checkbox"/> MRD <input type="checkbox"/>		IMPORTANT for all fetal samples Gestation: Parity Gravida: LMP EDD Multiple pregnancy? <input type="checkbox"/>		<input type="checkbox"/> Private <input type="checkbox"/> NHS
Specific molecular genetic tests sent required for DNA extraction and storage			EPIDIA TUBE		LITHIUM HEPARIN TUBE	
CLINICAL SUMMARY/ADDITIONAL INFORMATION/SPECIAL REQUIREMENTS (if several tests are required please indicate order of testing required)						
Acceptance of a testing request acts as an agreement with the requestor						
DNA testing (please specify test required)	Array CGH testing	Karyotyping	QF-PCR: aneuploidy	QF-PCR: gender	Mosaicism	FISH (please specify)
Breakage studies: Fanconi anaemia/Ataxia Telangiectasia/Other	Fixed cell storage for 2 years (blood only) (stored routinely for 4 months)	Fixed cell storage (oncology only)	Cell freezing (solid tissues/prenatal samples)	BGL use only Lab N°(s)		
<p><b>SENT STATEMENT</b> (please see overleaf): It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample may be used for future diagnostic testing. In signing this form the clinician obtains consent for testing, storage and for the use of this sample and the information gathered from it to be shared with members of the donor's family through their health professionals (if appropriate). The patient should be advised that the sample may be used anonymously for quality assurance and training purposes. If the patient does not wish information to be shared please write this clearly in the clinical summary box. Certain disorders with particular counselling issues (e.g. HD) require a specific consent form (see website for further details).</p>						
NAME:	SIGNATURE:		BLEEP No:			

BRISTOL GENETICS LABORATORY, SOUTHMEAD HOSPITAL, BRISTOL, BS10 5NB Tel: 0117 414 6168/6376/6174 Fax: 0117 414 6464 General enquiries email (not results): [nbn-tr.geneticsenquiries@nhs.net](mailto:nbn-tr.geneticsenquiries@nhs.net)