

Lab Number:

**MOLECULAR PATHOLOGY / HAEMATOLOGY TEST REQUEST FORM**  
**West of Scotland Genetic Services (Laboratories)**

Level 2, Laboratory Medicine, Southern General Hospital, Govan Road, Glasgow, G51 4TF



<http://www.nhsggc.org.uk/medicalgenetics>

ENQUIRIES Tel: 0141 354 9300 Fax: 0141 232 7980 Email: [geneticlabs@ggc.scot.nhs.uk](mailto:geneticlabs@ggc.scot.nhs.uk) or [gg-uhb.geneticsglasgow@nhs.net](mailto:gg-uhb.geneticsglasgow@nhs.net)

Please use printed barcode label if possible

|   |                 |   |   |   |     |
|---|-----------------|---|---|---|-----|
| Requested by: Consultant / GP   |                 | <b>CHI Number- This is essential</b>  |   | Date of Birth                             | Sex |
| Hospital/Site   |                 | Name  |   | Forename                                  |     |
| Ward/Dept   | Contact/Page No | Address   |   |   |     |
| Sample Date and time: <b>(Essential)</b>  |                 | ode:  |   |   |     |
| Destination for report:   |                 |   |   |   |     |
| Clinical Details:   |                 |   | <u>Diagnosis</u> <input type="checkbox"/>   | <u>Follow up</u> <input type="checkbox"/> |     |
|   |                 |   | <u>Priority:</u>  |   |     |
|   |                 |   | Routine <input type="checkbox"/>  | Urgent <input type="checkbox"/>           |     |
| <b>Please ensure all samples are sent NEXT DAY Delivery (especially QPCR &amp; CLL samples), to ensure that processing can be carried out.</b>  |                 |   |   |   |     |
| Please tick test required:  |                 | <u>Sample Type:</u> PB <input type="checkbox"/> BM <input type="checkbox"/> |   | <u>Date/Time Received</u>                 |     |
| <b>CML &amp; ALL</b> t(9;22) <i>BCR-ABL</i><br>(Qualitative diagnostic sample only) <input type="checkbox"/><br>20mls EDTA  |                 |   | <b>Myeloproliferative Neoplasm (5mls EDTA)</b><br>Must be specified, please circle type below<br>PV ET PMF  |   |     |
| <b>AML</b> t(15;17) <i>PML-RARA</i> <input type="checkbox"/><br>t(8;21) <i>AML1-ETO</i> <input type="checkbox"/><br>inv(16) <i>CBFB-MYH11</i> <input type="checkbox"/><br><i>FLT3 / NPM1</i> <input type="checkbox"/><br>(20mls EDTA) |                 |   | <b>POST TRANSPLANT CHIMÆRISM</b><br>Date of transplant: Sex of donor: M <input type="checkbox"/> F <input type="checkbox"/><br>Whole blood only (5mls EDTA) <input type="checkbox"/><br>Whole blood with lymphoid + myeloid split (20mls EDTA) <input type="checkbox"/> |   |     |
| <b>Pre-Transplant DNA Storage</b><br><br><b>Donor ID Number:</b><br>Donor <input type="checkbox"/><br><br>Patient sample <input type="checkbox"/><br>(5mls EDTA)  |                 |   | <b>CLL prognostic markers.</b><br>Initial Investigation <input type="checkbox"/><br>Follow-up (10mls EDTA) <input type="checkbox"/>   |   |     |
| <b>Q-PCR BCR-ABL</b><br>(Quantitative) <input type="checkbox"/><br>20mls EDTA   |                 | Transcript type: <b>(please circle)</b><br>P190 or P210                     |   |   |     |