NHS
South East
Genomic Laboratory Hub

KRCC MOLECULAR PATHOLOGY TEST REQUEST FORM

KingsRCC The Red Cell Centre

Please send all samples to:
Viapath Analytics Molecular Pathology Laboratory
c/o Central Specimen Reception
Blood Sciences Laboratory
Ground Floor Bessemer Wing
King's College Hospital, Denmark Hill
London SE5 9RS
Tel: 020 3299 2265 Email: kch-tr.PND@nhs.net

All fields are mandatory. Illegible, unclear or incomplete forms will result in delays or rejection.

CONSENT STATEMENT: 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 stored for future diagnostic testing. In signing this form the clinician has obtained 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.

PATIENT DEMOGRAPHICS	
First name:	
Last name:	
DOB:	**Gender:** Male ☐ Female ☐ Other ☐
NHS number:	
Hospital no:	**Family ref no:**
Postcode:	**Antenatal:** Yes ☐ No ☐
Non-NHSE funded (please attach invoicing details): ☐	

PATIENT ETHNICITY	
White:	British ☐ Irish ☐ Any Other White Background ☐
Mixed:	White And Black Caribbean ☐ White And Black African ☐ White And Asian ☐ Any Other Mixed Background ☐
Asian or Asian British:	Indian ☐ Pakistani ☐ Bangladeshi ☐ Any Other Asian Background ☐
Black or Black British:	Caribbean ☐ African ☐ Any Other Black Background ☐
Other Ethnic Groups:	Chinese ☐ Any Other Ethnic Group ☐ (please specify: _____)
Not stated ☐	**Not Known** ☐

PATHOLOGY RESULTS		**Haematology indices**			
Iron / liver parameters		Hb		HbF %	
Serum Iron		RBC		HbA2 %	
Serum TSat		MCV		Hb variant %	
Serum Bilirubin		MCH		Absolute Reticulocyte	
Serum Ferritin		Platelets		Reticulocyte %	
Blood Film comments:					

SAMPLE REQUIREMENTS	
For haemoglobinopathy investigation:	2 x 4 ml EDTA blood
Children and adults (all other tests):	4 ml EDTA blood
Infants:	1 ml EDTA blood
As DNA for Next Generation Sequencing:	3-5µg genomic DNA
As DNA for all other tests:	1-5µg genomic DNA

Date sample collected: _____

Reason for referral / family details: Affected ☐ Unaffected ☐

Molecular Tests - For Haemoglobinopathy referrals FBC and HPLC results MUST be provided

- ☐ R93 Hb variant identification
- ☐ R93 Haemoglobinopathy investigations
- ☐ R93 Alpha thalassaemia
- ☐ R93 Beta thalassaemia
- ☐ Other (please state gene): _____
- ☐ R176 Gilbert's genotyping ($TA_{5/6/7/8}$ repeat)
- ☐ R95 Hereditary haemochromatosis (HFE - C282Y and H63D variants)
- ☐ R191 Alpha-1-antitrypsin genotype (S and Z alleles)
- ☐ Thrombophilia genetic screen (please tick all that apply):
  FVL ☐ PT ☐ MTHFR ☐
- ☐ R240/242/244 Familial variant testing
  (please state familial variant): _____

For further details of each test please refer to the Viapath website.

Next Generation Sequencing - Please select which panel(s) are required

- ☐ R91 Cytopenia (NOT Fanconi anaemia)
  - ☐ Thrombocytopenia
  - ☐ Neutropenia
  - ☐ Diamond-Blackfan anaemia
  - ☐ Inherited bone marrow failure
- ☐ R313 Neutropenia consistent with ELANE mutations
- ☐ HLH
- ☐ Single gene analysis: _____ (name of gene)
- ☐ R96 Iron metabolism disorders
- ☐ R168 Porphyria
- ☐ R347 Inherited predisposition to AML
- ☐ R366 Inherited predisposition to CLL
- ☐ R405 Hereditary erythrocytosis
- ☐ R406 Thrombocythaemia
- ☐ R323 Sitosterolaemia
- ☐ R92 Rare Anaemia
  - ☐ Membranopathy
  - ☐ Enzymopathy
  - ☐ Haemoglobinopathy
  - ☐ Congenital dyserythropoietic anaemia
  - ☐ Diamond-Blackfan anaemia
  - ☐ Sideroblastic anaemia
  - ☐ Haemolytic anaemia
  - ☐ Sitosterolaemia
  - ☐ Megaloblastic anaemia

For details of genes in each subpanel, please refer to the Viapath website.

CLINICIAN DETAILS	
Requesting clinician / consultant Name: Hospital & department: NHS email: Phone:	Responsible clinician / consultant *(if different)* Name: Hospital & department: NHS email: Phone:

Note: Please ensure the latest version of this request form is used, found on our website: www.southeastgenomics.nhs.uk