SMA Test Synnovis Request Form

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. Testing may be performed at Synnovis, any other NHSE GLH or by other international laboratories where necessary. 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:		**Hospital no:**	
Last name:		**Family ref no:**	
Date of Birth:		**Postcode:**	
Sex assigned at birth:	Male ☐ Female ☐ Other ☐	**Ethnicity:**	
NHS number:			

Sample Type			***Clinician Details***
Blood EDTA ☐ for DNA or gene tests or **DNA (purified from EDTA blood)** ☐			Requesting Clinician / Consultant name: Hospital & Department : NHS email : Phone :
Sample Collection Date/Time:	...../...../.....	:	
For Departmental use only:			

Test Request

SMA RAPID TEST - URGENT ☐

Clinical Information and Family History

Please give as much clinical and genetic information as possible. Interpretation of results depends on the quality of clinical information provided. Please use HPO terms (https://hpo.jax.org/app/) when possible.

Has this patient had a bone marrow transplant or a blood transfusion? Yes / No
Date of bone marrow transplant or a blood transfusion:
Type of bone marrow transplant or a blood transfusion:

Main Clinical findings

	Yes	**No**
1. Muscle Weakness		
History of delayed motor milestones, especially with loss of skills Poor head control / Head lag Poor antigravity movements (especially lower limbs > upper limbs, predominantly proximal)		
2. Areflexia/hyporeflexia		
3. Normal facial expressions		
<u>Other Supporting clinical findings:</u>		
4. Tongue fasciculations		
5. Respiratory difficulty		
Recurrent lower respiratory tract infections or severe bronchiolitis in the first few months of life Paradoxical breathing Bell-shaped chest		
6.Feeding difficulty		

Invoicing: Non-NHSE funded (please attach invoicing details) ☐

***Disclaimer - the referral of any samples is acceptance of service provided by Synnovis which will be invoiced accordingly. If you wish to confirm pricing, please contact businessdevelopment@synnovis.co.uk**

Please send sample/s and completed form to this address:

Synnovis Genetics, Specimen Reception 5th Floor, Tower Wing, Guy's Hospital, Great Maze Pond, London, SE1 9RT
For all enquiries Email: SMA@synnovis.co.uk Tel: 02071881696/1709