

**PATIENT DETAILS**

Surname: \_\_\_\_\_

Forename: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

 Sex:    Male     Female 

Hospital/Clinic No.: \_\_\_\_\_

Laboratory No.: \_\_\_\_\_

Ward: \_\_\_\_\_

Physician: \_\_\_\_\_

**REQUESTING HOSPITAL/ CLINIC DETAILS**

Hospital / Clinic Name: \_\_\_\_\_

Department: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION**

**TESTS REQUIRED**

MOLECULAR GENETICS					
TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
ArrayCGH Analysis	CGH	<input type="checkbox"/>	Huntingtons Disease	HUNT	<input type="checkbox"/>
Chromosome Y Microdeletions	YQ	<input type="checkbox"/>	MTHFR Mutation C677T	MTHFR	<input type="checkbox"/>
Cystic Fibrosis Screen (most common mutations)	CF36	<input type="checkbox"/>	Muscular Dystrophy (Duchenne's)	DUCH	<input type="checkbox"/>
Factor V Leiden PCR	FAC5	<input type="checkbox"/>	Prothrombin (Factor II) Mutation	PTMUT	<input type="checkbox"/>
Fragile X Chromosome	FRAGX	<input type="checkbox"/>	Rett's Syndrome	RETT	<input type="checkbox"/>
Haemochromatosis	HFE	<input type="checkbox"/>	PAI-1 Mutation	PAI1M	<input type="checkbox"/>
			<b>Other Please Specify:</b> _____		
CYTOGENETICS					
TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
Chromosome Analysis / Karyotyping - Whole Blood	KARY	<input type="checkbox"/>	Prader Willi Syndrome (15q11- 13Methylation)	PRADW	<input type="checkbox"/>
Chromosome Analysis – Products of Conception	KARPP	<input type="checkbox"/>	William's Syndrome	WILL	<input type="checkbox"/>
			<b>Other Please Specify:</b> _____		
ONCOGENETICS					
TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
Chromosome Analysis/ Bone Marrow (Cytogenetic Bone Marrow)	KARYB	<input type="checkbox"/>	Philadelphia Chromosome (Bone Marrow)	PHIL	<input type="checkbox"/>
Philadelphia Chromosome (Whole Blood)	PHILB	<input type="checkbox"/>	<b>Other Please Specify:</b> _____		
Other Tests Required _____					

**SAMPLE DETAILS**

Specimen Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ / Specimen Type: \_\_\_\_\_

**CLINICAL INFORMATION**

Please note full clinical information is essential: *Please specify the condition/syndrome suspected clinically, if known:* \_\_\_\_\_

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**HAEMATOLOGICAL KARYOTYPE**
**Indication (necessary for conclusive interpretation)**
**Acute Leukaemia (AL):**

 Acute Lymphoid Leukaemia (ALL) 

 Acute Myeloid Leukaemia (AML) 

 Chronic Myeloid Leukaemia 

 Chronic Lymphoblastic Leukaemia 

 Lymphoma 

 Myeloma 

 Myelodysplastic syndrome (MDS) 

 Myeloproliferative syndrome 

 Fanconi anemia 

 Recent bone marrow transplant 
**Other (specify):** \_\_\_\_\_ 
**Immuno:** \_\_\_\_\_

**FAB Type:** \_\_\_\_\_

**CONSTITUTIONAL KARYOTYPE**
**In Infants**

 Small Birth Weight 

 Sexual Ambiguity 

 Hypotonia 

 Dysmorphic Syndrome 

 Malformation Syndrome 
**In children**

 Developmental Delay 

 Psycho-Motor Delay 
**In adolescents**

 Girls: Delayed Puberty 

 Boys: Gynecomastia 

 Boys: delayed puberty 
**In adults:**

 Multiple miscarriages: 

Number: \_\_\_\_\_

 Sterility or hypofecundity 

 Male infertility / abnormal sperm 

 Primary or secondary amenorrhea 

 Pre IVF 

 Pre ICSI 

**IMPORTANT:** Please note that in accordance with good clinical practice we will automatically perform additional tests for an accurate diagnosis where required. This will incur further charges and, where applicable, please ensure your patient is aware of this. We recommend that you obtain signed consent from the patient that they will accept such charges.

**INFORMED CONSENT SECTION**
**• Patient or Guardian:**

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist \_\_\_\_\_ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- determine heterozygote status with a view to obtaining genetic counselling.
- examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**• Doctor/ Pathologist/Genetic Consultant**

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Eurofins Biomnis. The result will be reported to the Physician only.

Doctor/Pathologist Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_