

**FAMILIAL HYPERCHOLESTEROLAEMIA**

**RARE DISEASE GENOMIC TEST ORDER FORM**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS (or address label)** | | | | | | | | | **REFERRER INFORMATION** | |
| NHS NO. |  | | | | | | | | SUBMITTER HOSPITAL  OR GP SURGERY  CLINICIAN NAME CONTACT EMAIL\* CONTACT PHONE  REPORT EMAIL\* |  |
| HOSPITAL NO. |  | | | | | | | |
| FAMILY NO. |  | | | | | | | |
| SURNAME |  | | | | | | | |  |
| FORENAME(S) |  | | | | | | | |  |
| DATE OF BIRTH |  | | | | | | | |  |
| POSTCODE |  | | | | | | | |  |
| ETHNICITY |  | | | | | | | | *\*NHS.net email required* | |
| GENDER |  | Male |  |  | Female |  | Other |  |

**SPECIMENS**

Blood (EDTA)

Saliva

DNA

Risk of infection

COLLECTION DATE

PREPARED BY (PRINT NAME)

**Affix risk of infection sticker here**

**or write in details of infection risk**

**GENOMIC TEST REQUIRED**

**FH DIAGNOSTIC TESTING** (R134)

Provide details of the patient

LDL CHOLESTEROL

Provide details for ONE of the following

**FH CASCADE TESTING**

Provide details of index patient and family FH genetic variant

mmol/L

SIMON BROOME

CRITERIA POSITIVE

YES

FH WALES

SCORE

DUTCH LIPID SCORE

INDEX PATIENT NAME INDEX PATIENT D.O.B GENETIC VARIANT

*provide gene name and variant information or send index patients report*

**RECORD OF DISCUSSION WITH PATIENT**

I HAVE DISCUSSED GENETIC TESTING FOR FAMILIAL HYPERCHOLESTEROLAEMIA WITH THIS PATIENT

*The FH test will look for genetic variants in only the genes known to cause FH.*

*The FH test may not identify a genetic cause of FH. This does not exclude a diagnosis of FH. The FH test results may be uncertain and change over time.*

*The FH test results may have implications for other family members.*

THIS PATIENT AGREES TO BE CONTACTED ABOUT OPPORTUNITIES TO TAKE PART IN RESERCH

*Research studies may lead to improvements in the diagnosis and treatment of Familial Hypercholesterolaemia, high lipid levels and cardiovascular disease.*

*If contacted the patient is under no obligation to take part in any research studies. This decision will not affect the care this patient will receive.*

YES

NO

**Send Completed Forms and Associated Specimens to:**

**Cambridge** University Hospitals Genomic Laboratory, Box 143, Cambridge University Hospital Foundation Trust, Cambridge, CB2 0QQ Tel: 01223 348 866

[geneticslaboratories@nhs.net](mailto:geneticslaboratories@nhs.net)

**Leicestershire** Cytogenetics Laboratory, University Hospitals of Leicester NHS Trust, Leicester, LE1 5WW Tel: 0116 258 5637

[uho-tr.uhlcytogenetics@nhs.net](mailto:uho-tr.uhlcytogenetics@nhs.net)

**Nottingham** University Hospitals Regional Genetics Laboratories, Nottingham University Hospitals NHS Trust, Nottingham, NG5 1PB Tel: 0115 969 1169, ext 56617(cyto) 55207(mol)

[NUHNT.cytogenetics@nhs.net](mailto:NUHNT.cytogenetics@nhs.net) or [NUHNT.MolecularGenetics@nhs.net](mailto:NUHNT.MolecularGenetics@nhs.net)

**Lab use only:**

**Affix Epic Label Here**

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