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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT DETAILS (or addressograph) | | | | | | | | | | | | REFERRER INFORMATION | | | | | | | | | | | | | | |
| NHS NO. | |  | | | | | | | | | | SUBMITTER HOSPITAL | | | | | | |  | | | | | | | |
| HOSPITAL NO. | |  | | | | | | | | | | CLINICIAN NAME | | | | | | |  | | | | | | | |
| SURNAME | |  | | | | | | | | | | SPECIALITY | | | | | | |  | | | | | | | |
| FORENAME(S) | |  | | | | | | | | | | CONTACT EMAIL \* | | | | | | |  | | | | | | | |
| DATE OF BIRTH | |  | | | | | | | | | | CONTACT PHONE \* | | | | | | |  | | | | | | | |
| POSTCODE | |  | | | | | | | | | | CC to: | | | | | | |  | | | | | | | |
| ETHNICITY | |  | | | | | | | | | | *\*Clinician contact for queries (Secure/NHS.net email required)* | | | | | | | | | | | | | | |
| GENDER | | M | | | | | F | | Other | | | NHS | | | | | PRIVATE | | | | | RESEARCH | | | | |
|  | |  | | | | | | | | | | **Invoices for non-NHS patients will be sent to referring clinician** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SPECIMENS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The full list of acceptable specimen types: <https://www.eastgenomics.nhs.uk/for-healthcare-professionals/genomic-tests/sample-requirements/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | | | | | |  |  | | | | | | | | | Y | | N |
|  | PERIPHERAL BLOOD | | | | | | | Danger of infection/High Risk Sample? | | | | | | | | |  | |  |
|  | BONE MARROW ASPIRATE | | | | | | |  | | | | | |  | Suspected/Known TB | | | | | | | | |  | |  |
|  | BONE MARROW TREPHINE | | | | | | |  | | | | | |  | Affix risk of infection sticker here  Or write in details of infection risk | | | | | | | | | | | |
|  | TISSUE BIOPSY, SPECIFY | | | | | | |  | | | | | |  |
|  | OTHER, SPECIFY | | | | | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COLLECTION DATE/TIME | | | | | |  | | | | | | PREPARED BY | | | | | | |  | | | | | | | |
| SPECIMEN ID | | | | | |  | | | | | | (PRINT NAME) | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GENOMIC TEST REQUIRED | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | URGENT | | IF URGENT RESULT REQUIRED, Please telephone the laboratory in advance | | | | | | | | | | | | | | | | | | | | | | | |
|  | JAK2 V617F (*M85.14*) | | |  | CALR Exon 9  (*M85.16*) | | | | |  | BCR::ABL1 Diagnostic PCR  *(non-urgent – TAT: 14 days)*  (*M85.11*) | | | | | | |  | | | BCR/ABL1 Diagnostic FISH  *(urgent ?CML – TAT: 3 days)*  (*M85.24*) | | | | | |
|  | JAK2 Exon 12  (*M85.15*) | | |  | MPL Exon 10  (*M85.17*) | | | | |  | BCR::ABL1 Monitoring for CML  (*M89.13*) | | | | | | |  | | | BCR::ABL1 Tyrosine Kinase Domain Mutation Analysis  (*M89.17*) | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CLINICAL INFORMATION - *Including suspected diagnosis, known transcripts, relevant therapies, and NGTD Clinical Indication Code* | | | | | | | | | | | | | RECENT FBC | | | | | | | DATE: | | | | | | |
|  | | | | | | | | | | | | | HB | | |  | g/l | | | NEUTROPHILS | | |  | | X109/l | |
| WBC | | |  | X109/l | | | MONOCYTES | | |  | | X109/l | |
| PLT | | |  | X109/l | | | LYMPHOCYTES | | |  | | X109/l | |
| MCV | | |  | fl | | | OTHER | | |  | |  | |
| NB National Genomic Test Directory (NGTD) codes can be found on:  <https://www.england.nhs.uk/publication/national-genomic-test-directories/> | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please Send Completed Form and Associated Specimens to: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cambridge University Hospitals Genomic Laboratory.  Box 143, Cambridge University Hospital Foundation Trust; Cambridge, CB2 0QQ  Tel: 01223 348 866 Email: [cuh.eastglh-haemonc-molecular@nhs.net](mailto:cuh.eastglh-haemonc-molecular@nhs.net) | | | | | | | | | | | | | | | | | | | | | | | | | | |