

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.**

<b>PATIENT DEMOGRAPHICS</b>		<b>PATIENT ETHNICITY</b>	
First name:		<b>White:</b>	British <input type="checkbox"/> Irish <input type="checkbox"/> Any Other White Background <input type="checkbox"/>
Last name:		<b>Mixed:</b>	White And Black Caribbean <input type="checkbox"/> White And Black African <input type="checkbox"/> White And Asian <input type="checkbox"/> Any Other Mixed Background <input type="checkbox"/>
DOB:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	<b>Asian or Asian British:</b>	Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background <input type="checkbox"/>
NHS number:		<b>Black or Black British:</b>	Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any Other Black Background <input type="checkbox"/>
Hospital no:	Family ref no:	<b>Other Ethnic Groups:</b>	Chinese <input type="checkbox"/> Any Other Ethnic Group <input type="checkbox"/> (please specify: _____)
Postcode:	Antenatal: Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Not stated</b> <input type="checkbox"/>	<b>Not Known</b> <input type="checkbox"/>
Non-NHSE funded (please attach invoicing details): <input type="checkbox"/>			

<b>PATHOLOGY RESULTS</b>		<b>Haematology indices</b>		<b>SAMPLE REQUIREMENTS</b>	
<b>Iron / liver parameters</b>		Hb		HbF %	
Serum Iron		RBC		HbA2 %	
Serum TSat		MCV		Hb variant %	
Serum Bilirubin		MCH		Absolute Reticulocyte	
Serum Ferritin		Platelets		Reticulocyte %	
Blood Film comments:				Date sample collected: _____	

**Reason for referral / family details:** Affected  Unaffected

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

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

For further details of each test please refer to the [Viapath website](http://www.viapath.nhs.uk).

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

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

For details of genes in each subpanel, please refer to the [Viapath website](http://www.viapath.nhs.uk).

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

Note: Please ensure the latest version of this request form is used, found on our website: [www.southeastgenomics.nhs.uk](http://www.southeastgenomics.nhs.uk)