

Patient Details	
Surname:	
Forename:	
DoB:	NHS No:
Sex:	Your Reference No:
Address:	
Postcode:	

Referring Clinician	
Consultant (surname in full):	
Hospital (in full):	
Department:	Tel:
Copy report to (if applicable):	
<p><b>Consent Statement</b> – It is the referring clinician's responsibility to ensure that the patient/ carer knows the purpose of the test.</p>	
Referring Clinician Signature:	

Sample Information	
High Infection Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Taken:
Sample Type:	
If a previous sample has been sent to the GDL, please complete the section below:	
Date Sent:	GDL Lab No:

Authorisation & Billing	
Authorising Consultant:	
Position/ Speciality:	
Hospital (in full):	
Department:	Tel:

Export Request Details	
Export To:	
- If no centre is specified the GDL will attempt to identify the most appropriate centre.	

<p><b>Authorising Statement</b> – By authorising this form you agree to pay all charges incurred by exporting this sample and cost of testing.</p>
Authorising Signature:
Test Costs (contact the GDL for current charges): £
Billing Address (if different from Referring Clinician):
Postcode:

Guidance notes shown over page, further details can be found at [ManGen.org.uk](http://ManGen.org.uk)

Test Requested:	
- Include clinical indications, pedigree and details of familial mutation of proband if relevant.	
Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent Prenatal <input type="checkbox"/> Urgent Predictive	

Genomic Diagnostics Laboratory Use Only		GDL Barcode
<b>Molecular Pre-Analytical</b>		
<b>Routine</b>	<b>FastTrack</b>	<b>Urgent</b>
		<b>High Risk: Yes No</b>
Blood: EDTA Li-Hep Blood-Spot Other → Specify:		
Tubes:	< 1ml: Y / N	Spare: Y / N
Fixed Tissue: Wax-Block Shavings Slides		
Stained: Y / N	No of Slides:	
Marked: Y / N	Path #:	
Fresh Tissue → Specify:		
DNA → Lab #:	Vol: µl	
Prenatal:	Amnio	CV Cultured Cells
<b>Mouth-Wash</b>		<b>Mouth-Swab</b>
<b>Chemagen (1-3ml)</b>		
<b>COBAS Phenol-Chloroform</b>		
EZ1 → Specify:		
Mol Tech (Check):		
Mol Tech (Transfer):		
Duty Scientist:		
Date Exported:	Exported By:	

Attached Documentation:  Letter  Pedigree  Billing Details  Other → Specify:

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**Genomic Diagnostics Laboratory (GDL)**

Manchester Centre for Genomic Medicine (MCGM)

Central Manchester University Hospitals NHS Foundation Trust

6th Floor, Saint Mary's Hospital, Oxford Road, Manchester, M13 9WL

### Guidance Notes – Molecular Testing Export Request Form – V8.0

#### Important Notes

If a molecular genetic test is not available within the GDL we can arrange sample processing and export for testing in an external laboratory.

Please note the Referring Clinician will be invoiced for the test.

The form must be completed and signed for ALL samples exported for testing (irrespective of whether or not testing incurs a cost).

Please note that failure to send this form may result in a delay in testing.

If the laboratory cannot verify the patient due to missing information from the Patient Details section, forms will be returned to the Referring Clinician.

#### Patient Details

Patient Details should be completed as fully as possible, the following are mandatory:

- Surname & Forename
- Date of Birth (DoB)
- NHS Number (10 digits)
- First line of Address & Postcode

#### Export Request Details

**Date Original Sample Sent to GDL:** When was the original sample sent to the GDL for DNA extraction.

The Export Request Form should not be sent in advance of the original sample sent for DNA extraction, forms sent in advance will be returned to the Referring Clinician.

**Test Requested:** Please state the test required including:

- Clinical indications
- Pedigree of family
- Full details of other family members previously tested and specific mutations investigated
- Please attach further letters or correspondence related to previous testing

**Export To:** The centre where the sample is to be exported to, If blank the GDL will attempt to identify the most appropriate centre to send the sample to.

If advice is required regarding available services and current charges please contact the Duty Scientist at the GDL.

Exported samples destined to be sent outside the UK will not be sent to a PO Box Number.

**Attached Documentation:** Please indicate which documentation is attached to this form. The sample for export will not be processed until all the relevant attachments are available to accompany the sample.

#### Referring Clinician

**Consultant** name is mandatory, initials are not acceptable as the laboratory cannot identify the consultant.

**Hospital** should be clearly identifiable, initials are not acceptable as the laboratory can not identify the hospital.

**Department** should be clearly identifiable, initials are not acceptable as the laboratory can not identify the department.

**Copy report to** is optional, if more space is required please use the Clinical Indications & Test Details box.

**Consent Statement** must be signed for the sample or form to be accepted and processed by the laboratory. Note where possible an aliquot of DNA is archived for possible future genetic testing.

#### Authorisation & Billing

**Authoring Consultant** name is mandatory, initials are not acceptable as the laboratory can not identify the consultant.

**Position/ Speciality** must be clearly identified as they are authorising the referring centre to be billed for all costs incurred with exporting this sample.

**Hospital** should be clearly identifiable, initials are not acceptable as the laboratory can not identify the hospital.

**Department** should be clearly identifiable, initials are not acceptable as the laboratory can not identify the department.

**Authorising Statement** – By authorising this form you agree to pay all charges incurred by exporting this sample and cost of testing.

Please note the sample will not be exported without an authorising signature and a Billing Address.

**Billing Address** should be clearly identifiable if different from the Referring Clinician.

#### Useful Information Sources

**UK Genetic Testing Network:** [www.ukgtn.nhs.uk](http://www.ukgtn.nhs.uk)

**GeneTests:** [www.genetests.org](http://www.genetests.org)

**Orphanet:** [www.orpha.net](http://www.orpha.net)

#### GDL Contact Details

**Website:** [www.ManGen.org.uk](http://www.ManGen.org.uk)

**Duty Scientist Email:** [MCGM.DutyScientist@cmft.nhs.uk](mailto:MCGM.DutyScientist@cmft.nhs.uk)

**Telephone:** 0161 276 6122      **Secure Fax:** 0161 276 6606

**Laboratory Opening Hours:** 09:00 – 17:00, Monday to Friday

#### Delivery Address

**Genomic Medicine, 6th Floor,  
Saint Mary's Hospital, Oxford Road,  
Manchester, M13 9WL, United Kingdom.**