TDL GENETICS LTD
The Halo Building
1 Mabledon Place
London WC1H 9AX
Tel: 020 7307 7409
Fax: 020 7307 7350
Email: tdlgenetics@tdlpathology.com

CLINICIAN

Doctor

Address

Tel Email

Additional copy of results to:

TAP1929C/02-12-21/V16

SURNAME		DOB or AGE	Patient Ref. No.	Gestation
FORENAME	TITLE			

Clinical Details – include reason for test request and family history
(Please complete this box – details are crucial for analysis and interpretation)

Identified gender	☐ M ☐ F
Biological sex (if different)	☐ M ☐ F

PRENATAL NT: Risk: Abnormal U/S Findings:

No of fetuses:

PRENATAL ASSAYS

- ☐ **Amnio PCR**
- ☐ **Amnio Karyotype**
- ☐ **Amnio PCR & Karyotype**
- ☐ **∝FP**
- ☐ **CVS PCR**
- ☐ **CVS Karyotype**
- ☐ **CVS PCR & Karyotype**
- ☐ **Microdeletions BOBs**
- ☐ **Prenatal Microarray (Array CGH)**
- ☐ **UPD** specify chromosome _____

Please *ensure* options* below are completed.

***Fetal sex to be reported**

Yes ☐ **No** ☐

***p.F508del Cystic Fibrosis**
Only available as part of Amnio/CVS PCR:

Yes ☐ **No** ☐

***Fee for these options is included in test price.**

POSTNATAL ASSAYS

- ☐ **Blood PCR (T13, T18, T21, X and Y)**
- ☐ **Chromosome Analysis Karyotype – blood**
- ☐ **Chromosome Analysis Karyotype from G banded slide**
- ☐ **Postnatal Microarray (Array CGH)**
- ☐ **Chromosome Analysis Karyotype of Solid Tissue/Products of Conception****
  Reflex to aneuploidy BOBs in the event of culture failure

BACs on Beads (BOBs)

- ☐ **Microdeletion/Duplication Syndromes All** (or select individual tests below)
  - ☐ **Di George/VCFS**
  - ☐ **Miller-Dieker**
  - ☐ **Cri du Chat**
  - ☐ **Williams**
  - ☐ **Wolf-Hirschhorn**
  - ☐ **Smith-Magenis**
- ☐ **Products of Conception Aneuploidy BOBs****

** Material from miscarriage samples can be returned upon request at the time of referral. Please instruct if required. Full details of sensitive disposal can be found in the lab guide.

DNA ASSAYS

- ☐ **CF (139 Mutations)**
- ☐ **Haemochromatosis mutations – C282Y,H63D**
- ☐ **Y Chromosome Microdeletion**
- ☐ **Paternity Testing**
- ☐ **DNA Identity Profile**
- ☐ **Uniparental Disomy**
- ☐ **Factor II Prothrombin**
- ☐ **Factor V Leiden**
- ☐ **MTHFR – C677T, A1298C**
- ☐ **Duchenne Muscular Dystrophy**
- ☐ **Spinal Muscular Atrophy**
- ☐ **Prader Willi/Angelman methylation**

- ☐ **Zygosity Testing**
- ☐ **Apo E Genotype**
- ☐ **HLA Tissue Typing**
  (A,B,Cw,DR,DQ Coeliac/Narcolepsy)

Please specify

_____

- ☐ **HLA B27**
- ☐ **DNA extraction and storage**

For 3 years unless otherwise stated

_____

PROFILES

Male Genetic Reproductive Profile ☐
Y Chromosome Microdeletion DNA Studies / Cystic Fibrosis Carrier Screen / Chromosome analysis (Karyotype)

Iron Overload Profile ☐
Iron / Total Iron Binding Capacity / Ferritin / Haemochromatosis mutation

Ashkenazi Jewish Carrier Screen (see lab guide for details) ☐

Pan Ethnic Carrier Screen (see lab guide for details) ☐

Other tests:

Fee to be paid by: ☐ Dr ☐ Patient

Patients address and telephone number (essential information if patient to pay)

Address

Town/City Postcode

Contact telephone number

Tick if a Letter of Guarantee is required ☐

Laboratory notes:

For Practice Use Only:

EDTA	LH	AMNIO	CVS	POC	OTHERS

Sample Date | Sample Time

For TDL Genetics Use Only:

EDTA	LH	AMNIO	CVS	POC	OTHERS

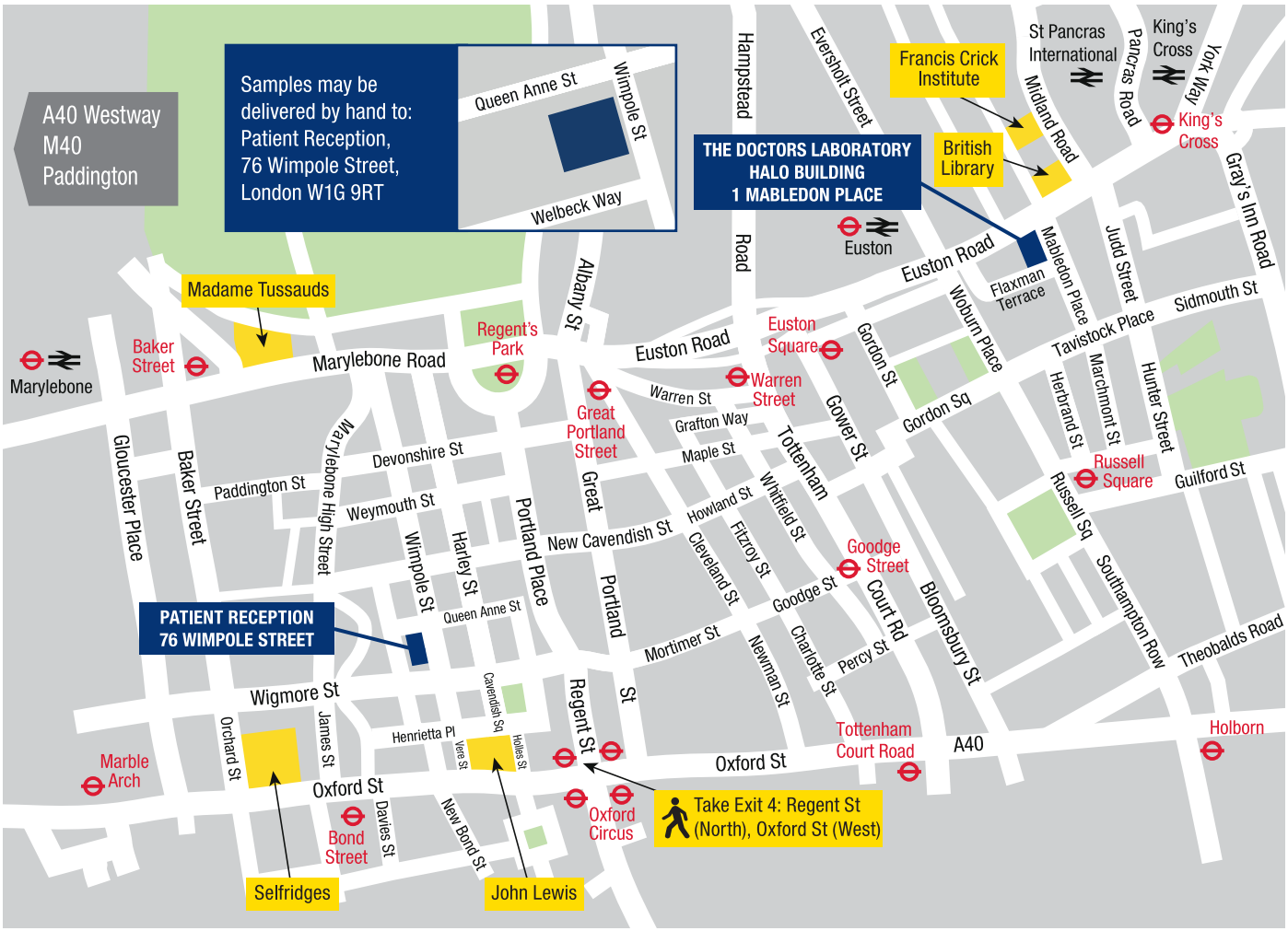
Analysis

Date/Time received:

For further test information or sample requirements please refer to Laboratory Guide or contact Dr Lisa Levett on 020 7307 7409.

Patient Consent: Patient consent is inferred upon the receipt of a completed request form and appropriate sample, unless otherwise stated in the laboratory guide. It is the responsibility of the referring clinicians to ensure appropriate consent has been obtained.

TDL GENETICS



SENDING SAMPLES TO THE LABORATORY

TRANSPORT ARRANGEMENTS

All specimens should be kept at room temperature and despatched to the laboratory as soon as possible, by TDL/international courier, first class post, guaranteed next day delivery or a reliable alternative.

If a delay in sending the sample is unavoidable, please refrigerate overnight – DO NOT FREEZE. Specimens must not be allowed to come in contact with request forms, but should be kept separate by using dual – pocketed plastic bags. Specimens for inland postage must be packed in a rigid crush-proof container according to current Post Office guidelines. IATA guidelines should be followed for international transport (Advice is available from the laboratory).

LABELLING OF HIGH RISK SAMPLES

Please note that it is the responsibility of the referring clinician to ensure that high-risk samples are clearly identified to reduce the risk of infection to staff and others.

PATIENT DETAILS ON REQUEST FORMS AND SAMPLES

Request and consent forms are available directly from TDL Genetics.

In order to avoid unnecessary time spent in obtaining details please provide the following information:

Information for request forms:

- Surname, forename (not initials) and date of birth
- Full name (not initials) and location of referring clinician
- Full address of clinician to whom the result should be sent
- Legible clinical summary, including details of any relevant family history
- Address for billing – Doctor, patient or other
- Gestation on prenatal samples
- Hospital or reference number
- Test required

Essential information on sample container label:

- Patients surname and forename (not initials)
- Date of birth
- Hospital number or reference number

CONSENT FORMS

Consent forms (at the back of this booklet) are available for genetic testing. As genetic testing may have implications for other family members and is regarded as personal data, it is recommended that written consent is obtained wherever possible. In cases with predictive testing for severe disorders, as indicated in the laboratory guide, it is essential that patients should also be offered formal genetic counselling. It is the responsibility of the referring clinician to obtain appropriate consent from the patient.

UNLABELLED SAMPLES

Unlabelled samples will ONLY be processed if the individual who took the sample can confirm the sample is from the patient in question. In the absence of this assurance, the sample will be discarded and a repeat required.

Consent Form

TDL GENETICS

The Halo Building, 1 Mabledon Place, London WC1H 9AX
Tel: 020 7307 7409 Fax: 020 7307 7350
Email: tdlgenetics@tdlpathology.com

PATIENT OR GUARDIAN

Please cross-out where applicable.

I consent / do not consent to be tested for the genetic test/tests which have been explained to me.

I consent / do not consent for the results of this test to be available to assist in testing other family members.

I consent / do not consent for DNA from this sample to be stored.

I consent / do not consent for DNA to be used anonymously for relevant research.

Signed _____

Date ____/____/____

DOCTOR

I have explained the purpose of obtaining a blood or tissue sample for genetic testing.

Signed _____

Date ____/____/____

This consent form is for use with diagnostic testing. It is important to think through the implications of genetic testing for other family members. Certain family studies may reveal information regarding paternity. We strongly recommend genetic counselling for predictive testing in disorders such as Huntington's Disease or inherited cancers. Please contact our Consultant if you have queries about consent or counselling issues.