CANCER GENETICS REFERRAL FORM - LIQUID SAMPLES

Patient Details

Surname: Forename:

DOB: Sex: M / F

Hospital Number:

NHS Number:

Referring Hospital

Hospital:

Consultant:

e-mail address:

Signed:

Clinical details/reason for referral:

☐ **Urgent** ☐ **Routine**

If urgent, please state why and give date if applicable

Sample type:

☐ **BM**

☐ **PB**

☐ **Other (specify):**

Date sample taken:

Time sample taken:

Test requested - cytogenetics

☐ **Karyotype**

☐ **FISH (specify):**

Please send PB samples in lithium heparin or bone marrow transport medium.
All other samples in bone marrow transport medium.

Address for samples

Cytogenetics: Genetics, 5th Floor Tower Wing, Guy's Hospital, Great Maze Pond, London SE1 9RT
Telephone: 020 7188 1709

In submitting this sample the clinician confirms that consent has been obtained for testing and possible storage

Cancer Genetics	Date received	Time received