NHS
London South
NHS Genomic Laboratory Hub

MOLECULAR MINIMAL RESIDUAL DISEASE MONITORING REQUEST FORM FOR NON-TRIAL SAMPLES

Request forms from: www.londonsouthgenomics.nhs.uk

Please complete electronically if possible. Incomplete forms will result in delays or rejection.

PATIENT DETAILS

Last name:

First name:

DOB:

NHS number:

Originating Lab No:

Purchase Order No:

Non-NHSE Funded i.e. Research/Private ☐ (please attach invoicing details)

PATIENT ETHNICITY

White:	British ☐ Irish ☐ Any Other White Background ☐
Mixed:	White And Black Caribbean ☐ White And Black African ☐ White And Asian ☐ Any Other Mixed Background ☐
Asian or Asian British:	Indian ☐ Pakistani ☐ Bangladeshi ☐ Any Other Asian Background ☐
Black or Black British:	Caribbean ☐ African ☐ Any Other Black Background ☐
Other Ethnic Groups:	Chinese ☐ Any Other Ethnic Group ☐
Not stated ☐	**Not Known** ☐

Sample type

Sample collection date and time

5ml Bone Marrow in EDTA ☐ ____/____/____

20ml Peripheral Blood in EDTA ☐ ____/____/____

Other (cDNA/gDNA/RNA/TRIzol/RLT) – please specify: _____ ☐ PB ☐ BM ____/____/____

Baseline data (*not required if previous patient samples have been analysed and reported*)

Analysed before? Yes ☐ No ☐ *please provide details below*

Date of diagnosis: _____ Karyotype: _____

NPM1: Yes ☐ No ☐ FLT3-ITD: Yes ☐ No ☐ FLT3-TKD: Yes ☐ No ☐

Name of local molecular lab:_____ (*for enquiries or retrieval of diagnostic material if necessary*)

Routine sample information

☐ New diagnosis ☐ On treatment (post course: _____) ☐ Post transplant (day: _____)

☐ Follow-up (month: _____) ☐ Relapse ☐ Other _____

Test required

☐ Molecular MRD Target _____ (*please refer to the GLH website for a list of targets*)

☐ Other _____ (*please discuss with laboratory **prior** to request e.g. RNAseq/ddPCR/NGS*)

CLINICIAN DETAILS

Requesting Clinician / Consultant:
Hospital:
Referring lab (if different):
Clinician e-mail:
Contact: Phone / Bleep
Signature: _____ **Date:** ____/____/____

Main contact (if different from responsible clinician/consultant):
Contact e-mail:

Transplant Centre (if relevant):
Contact at centre:
Contact e-mail:

Please send all samples to:
Molecular Oncology Diagnostics Unit - Viapath
4th Floor Southwark Wing, Guy's Hospital
Great Maze Pond, London SE1 9RT

Lab contact: 020 7188 7188 ext 51060
Email: gst-tr.amlmrd@nhs.net

For clinical enquiries please email: richarddillon@nhs.net

Please ensure tubes are clearly labelled peripheral blood (pb) or bone marrow (bm).
In submitting this sample, the clinician confirms that consent has been obtained for testing and storage.

LAB USE ONLY **Date sample received:** _____ **Time sample received:** _____