

The Test: Purpose and Process

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North West Coa

NHS Genomic Medicine Centre

The Test: Purpose and Process

- Sample requirements.
- Time frames
- Sample storage in lab
- Test request paperwork





The Test: Purpose and Process



- Sample requirements:
- Venous Blood: use EDTA tube only:
- 4ml for adults (BD Vacutainer preferred).
- Saliva Samples: GeneFiX or Oragene collection kits only.
- Other Sample Types: by prior arrangement only.









- Time Frame
- Results will take approximately 6 weeks









- Sample storage in the lab
- DNA will be stored in lab in case further testing is required unless patient opts otherwise.







The Test request paperwork:

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North West	Hub	Genor	nic Testing Rare Dis (DOC4900 Rev		1		b use only	
Patient Details – use sticker if avai	sing information	Referri	ng Clir	nician/Health	are Professional			
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Patient's		Ethnicity:	0	Department	:	0		
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N.B. Samples will not be accepted								
Clinical Indication Code e.g. R53, Fragile X):	R							
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High Infection Risk? [🛛] Yes	[0]	No	Sample Date:	0		Taken by:	٥	
Sample Type:			Further Details:	٥		Fetal Gestation:		
Once taken, samples should	be sent	to your loca	Genomics Lab	oratory				
		Manchester			Liver	pool		
N/F/S							oratory Hub – Liverpool Site	
<u>N/F/</u>	North West Manchester Cer Sample Reception St Mary's Hospit			Itrefor Genomic Medicine Manc on (6 th Floor) Samp al Liver		nchester Centrefor Genomic Medicine nple Reception (2 nd Floor) erpool Women's Hospital wn Street		
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NHS Genomic Laboratory I	Hub	https://mft.nhs.uk/nwglh/ St Mary's Hospit Oxford Road Manchester				ool		
NHS Genomic Laboratory I	Hub //	Oxford Road			Liverp L8 7SS Tel: 01	ool	inet	

Guidance Notes – Genomic	Testing Request Form – Rare Disease
Patient Details	Specimen Details
The following details are mandatory, other details should be completed as fully a possible: Survame & Forename D.O.B. – Oate of Sirth D.O.B. – Oate of Sirth D. Wis Nume (10 digts) P. Patient's Biological Sex P. Patient's Biological Trute Sex P. Patient's	High Infection Risk: In accordance with the Health & Safety at Work Act and COSH Regulations, the laboratory must be informed of any infection risk associated with bothtical samples. The sarefar has the responsibility for minimizing the risk to appropriate safety presultions when testing a specimen. Protonalal samples for NAA estatus (all genomics testing except Responsible safety presultions when testing a specimen. Protonalal samples (FM A exact Action (all genomics testing except Responsible safety presultions when testing a specimen. Protonalal samples (FM A exact Action (all genomics testing except Responsible safety presultions when testing a specimen. • Venous (Bod use DTAA the only) • 4 and for adults and children (BO Acctations preferred). • Safets Samples, Cameritik or Gragetic acclection bits only. • Cather Sample types: by any arrangement only. • Postnatal samples for Karyotyping, FISI and Repid Anceptology Testing - Store overingite at K-1 (required, DO NOT freeze or excepted to hast. The any constraints (Bod in the prior) (bod in the only.
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Patient demographics:

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North West NHS Genomic Laboratory Hub		(DOC4900 Revision 2)		
Patient Details – use sticker if available but pl	lease add any mis	sing information	Referring Cl	inician/Healthcare Professional
NHS No:	D.O.B.:		Consultant/GP:	
Surname:	Biological Sex:		E-mail/Tel:	
Forename:	Gender		Hospital/Surgery:	
Patient's	Identity: Ethnicity:		Department:	
Address: Postcode:	Hospital No:		Requested by/ Cc. Report to:	
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Predictive/Pre-symptomatic Test				teria and provide any additional pertinent ily members and familial variants.
Prenatal Test (Please Indicate Fetal Gestation				
Carrier Test (Recessive Disorder) Family studies				
DNA STORAGE ONLY, NO TESTING (Tick this)	box ONLY)			
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FISH				
Rapid Aneuploidy				
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Long Term Storage of Cells (state blood/tiss Please tick if the patient does NOT want any remain		N.B. WGS requests and	l certain specialist se	rvices require an additional proforma:
Please tick if the patient does NOT want any remain		N.B. WGS requests and https://mft.nhs.uk/nwglh		ervices require an additional proforma: st-forms/
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Patient details



Mandatory Fields. Can use sticker and fill in additional boxes by hand

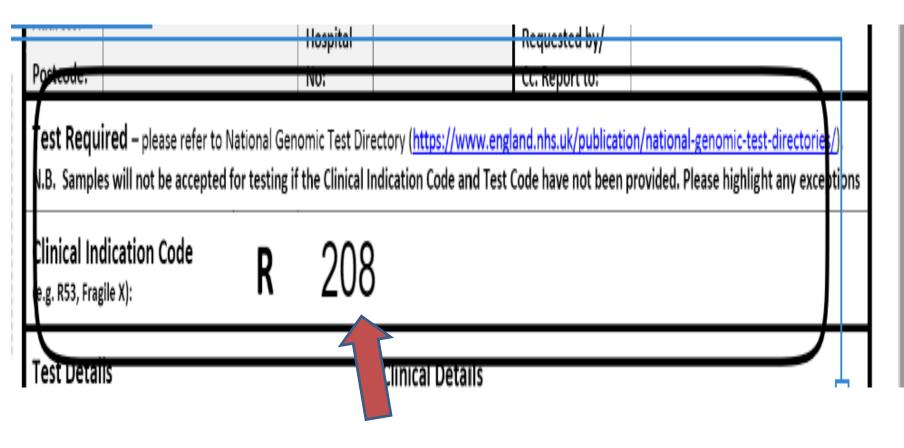
NUC	Genomic Testing Re	quest Form	Lab use only Lab No:
	Rare Diseas	se	
North West NHS Genomic Laboratory Hub	(DOC4900 Revision	2)	
Patient Details – use sticker if available but	please add any missing information	Referring Cli	nician/Healthcare Professional
NHS No:	D.O.B.:	Consultant/GP:	\star
Surname:	Biological Sex:	E-mail/Tel:	$\mathbf{\star}$
Forename:	Gender Identity:	Hospital/Surgery: (in full)	*
Patient's	Ethnicity:	Department:	*
Address:	Hospital	Requested by/	* /
Postcode:	No:	Cc. Report to:	



Test required:

North West NHS Genomic Laboratory Hub	Genor	nic Testing Reque Rare Disease (DOC4900 Revision 2)	est Form	Lab use only Lab No:
Patient Details – use sticker if available but	please add any mis	sing information	Referring C	linician/Healthcare Professional
NHS No:	D.O.B.:		Consultant/GP: (in full)	
Surname:	Biological		E-mail/Tel:	
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	Hospital		Requested by/	
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High Infection Risk?		Sample Date:		Taken by:
Sample Type:		Further Details:		Fetal Gestation:
Once taken, samples should be sen	t to your local	Genomics Laboratory		
North West NHS Genomic Laboratory Hub https://mtt.nhs.uk/wgih/ Laboratory Opening Hours:	Manchester Cent Sample Receptio St Mary's Hospita Oxford Road Manchester M13 9WL	al	ester Site Nori Mar Sam Live Crow Live L8 7	
09:00 – 17:00. Monday to Friday	Tel: 0161 276 61	22	Tel:	0151 702 4228





Pre-filled test code

Test Details

North West	Genor	nic Testing Requ Rare Disease (DOC4900 Revision 2)		Lab use only Lab No:
Patient Details – use sticker if available but	please add any mis	sing information	Referring C	linician/Healthcare Professional
NHS No:	D.O.B.:		Consultant/GP: (in full)	
Surname:	Biological		E-mail/Tel:	
Forename:	Sex: Gender Identity:		Hospital/Surgery: (in full)	
Patient's Address:	Ethnicity:		Department:	
Postcode:	Hospital No:		Requested by/ Cc. Report to:	
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	Family studies				
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	Karyotyping		Family studies		
	FISH		DNA STORAGE ONLY, NO TESTING (Tick this box ON	ILY)	
	Rapid Aneuploidy				
	Long Term Storage of Cells (s	tate bloo	/tissue type below)		
	tick if the patient does NOT was tored in the laboratory \Box	ant any re	naining DNA, RNA or N.B. WGS requests and certain spe https://mft.nhs.uk/nwglh/documents/t		

Clinical details

North West		Rare Disease		
NHS Genomic Laboratory Hub		(DOC4900 Revision 2)		
Patient Details – use sticker if available but	please add any miss	sing information	Referring Cli	nician/Healthcare Professional
NHS No:	D.O.B.:		Consultant/GP: (in full)	
Surname:	Biological		E-mail/Tel:	
Forename:	Sex: Gender		Hospital/Surgery:	
	Identity:		(in full)	
Patient's Address:	Ethnicity: Hospital		Department: Requested by/	
Postcode:	No:		Cc. Report to:	
N.B. Samples will not be accepted for testir Clinical Indication Code (e.g. R53, Fragile X):				ANY NEW CONTRACT OF ANY
Test Details		Clinical Details		
Microarray Diagnostic Screen/Test		 By requesting this test you defined by the National Generational Generational Generation 		is patient meets the eligibility criteria as
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Clinical Details

- By requesting this test you are confirming that this patient meets the eligibility criteria as defined by the <u>National Genomic Test Directory.</u>

- Please list how the patient meets the testing criteria and provide any additional pertinent clinical information and/or details of affected family members and familial variants.

Patient has a personal history of triple negative breast cancer aged 35 years and wider family history in her mother aged 54 and maternal Aunt aged 49 years.

N.B. WGS requests and certain specialist services require an additional proforma: https://mft.nhs.uk/nwglh/documents/test-request-forms/

Option Not to store DNA

Patient Details – use sticker if available but p	please add any miss	ing information	Referring Cli	nician/Healthcare Professional
NHS No:	D.O.B.:		Consultant/GP: (in full)	
Surname:	Biological Sex:		E-mail/Tel:	
Forename:	Gender Identity:		Hospital/Surgery:	
Patient's	Ethnicity:		Department:	
Address: Postcode:	Hospital No:		Requested by/ Cc. Report to:	
Test Required – please refer to National G N.B. Samples will not be accepted for testin Clinical Indication Code (e.g. RS3, Fragile X):		ndication Code and Test Co		
Test Details		Clinical Details		
Microarray Diagnostic Screen/Test Diagnostic Screen/Test Predictive/Pre-symptomatic Test PrenatarTest (Please Indicate Fetal Gestal Carrier Test (Recessive Disorder) Family studies		defined by the National Gen - Please list how the patient	mic Test Directory. meets the testing crite	is patient meets the eligibility criteria as eria and provide any additional pertinent ly members and familial variants.
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Option Not to store DNA

Long Term Storage of Cells (state blood/tissue type below)

Please tick if the patient does NOT want any remaining DNA, RNA or cells stored in the laboratory \Box

consent statement. Receipt of this form and samplets) by the laborato

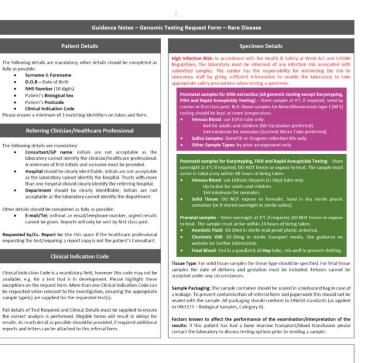
Specimen details:

Test Details		Clinical Details		
Microarray Diagnostic Screen/Test Predictive/Pre-symptomatic Test Prenatal Test (Please Indicate Fetal Gesta Carrier Test (Recessive Disorder) Family studies	ation below)	By requesting this test you are confirmin defined by the <u>National Genomic Test Dir</u> Please list how the patient meets the te clinical information and/or details of affer	ectory. sting criter	ria and provide any additional pertinent
DNA STORAGE ONLY, NO TESTING (Tick th	his box ONLY)			
Karyotyping FISH Rapid Aneuploidy				
Long Term Storage of Cells (state blood/t lease tick if the patient does NOT want any rema	N.B. WGS requests and certain spec		vices require an additional proforma:	
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Consent Statement: Receipt of this form and sample(s) by the laborat	ory assumes that the clinician has obtained consent	tor genomic testing and for the use of the DNA T

Specimen Details	;		EDTA Blood (1-4ml): Ideal for DNA storage and all Genomic Testing except Karyotyping, FISH and Rapid Aneuploidy Tes Lithium Heparin (Li-Hep) Blood (1-6ml): For Karyotyping, FISH and Rapid Aneuploidy Testing					
High Infection Risk?		Yes		No	Sample Date:	Taken by:		
Sample Type:					Further Details:	Fetal Gestation:		
	ples	should b	oe sent t	o your loca	Further Details:	Fetal Gestation:		

2nd page



This area is for Lab use only