All Wales Genomics Laboratory

Chromosome / FISH analysis: Lithium heparin (5mls*)

Molecular investigations: EDTA (5-10 mls*)

Prenatal investigations: See over*

For enquiries, please call (029) 2184 4023

InnerWorkings Europe Ltd

LGSFW RF
Version 01/18

PLACE LABELLED SPECIMEN IN BAG
REMOVE PROTECTIVE STRIP, FOLD FLAP
ONTO BAG AND SEAL FIRMLY

FCN648317-00

ALL WALES MEDICAL GENOMICS SERVICE (AWMGS)

(Please apply patient label if available)

Name of Patient:

Address:

Postcode:

NHS / Hospital Number:

Hospital

Ward / OP Clinic

D.O.B.

SEX

Family Number (Clinical Genetics)

Consultant/GP (Block letters)

Requested by: (Block letters)

Bleep No.

Signature

Additional copies of results to:

For Lab. use:

Cyto No.

DNA No.

Sample(s)	*Volume(s)*
EDTA	
Heparin	
Other	

Date of receipt: ...../...../.....

Time of receipt:

Date request activated

...../...../.....

Specimen

Danger of infection? ☐ Y / N ☐

Provisional diagnosis

Investigation(s) required
(Please circle and write details of test below)

☐ *DNA / Chromosome* ☐ *FISH* ☐

Details of test:

Signed consent for test (see over)

Sample collection

Date ...../...../..... Time:

☐ **NHS / Private** ☐
/ Research *(circle)* ☐

Relevant clinical details (If family history available – see over).

For Prenatal samples:

Operator (Person taking sample)

Gestation:

LMP:

Additional information required before culture / analysis:

Linked Nos.:

Results summary:

Analysed by: .....

Checked by: .....

Date report issued

...../...../.....

Please forward sample to: All Wales Medical Genetics Service, Canolfan Iechyd Genomig Cymru (CIGC), Cardiff Edge Business Park, Longwood Drive, Whitchurch, Cardiff, CF14 7YU

TO AVOID DELAY PLEASE FILL IN ALL DETAILS LEGIBLY AND ACCURATELY

All Wales Medical Genetics Service, Canolfan Iechyd Genomig Cymru (CIGC),
Cardiff Edge Business Park, Longwood Drive, Whitchurch, Cardiff, CF14 7YU

Family pedigree details if required

Please mark * against persons who have been sampled for inclusion in linkage/mutation/ cytogenetic investigation and include their *full name and date of birth* on the family tree.

(Results are dependent on the samples being correctly labelled and family relationships being as indicated.)

Patient Consent

I confirm that .....has explained
(professional's name)
the genetic test that I am about to have done

with respect to .....
(genetic condition)

Signature: ..... **Date:** .....

Health Professional:
..... **Date:** .....

N.B. For **presymptomatic** molecular diagnosis - Clinical Genetics referral indicated.

FOR LAB. USE ONLY

Telephone Resu☐ eq☐ / Message (☐). *Details:*

By:

To:

Date:

PLEASE INSERT SPECIMEN(S) IN BAG ON REVERSE OF FORM AND SEAL FIRMLY