All Wales Medical Genomics Service-Whole Exome Sequencing Request Form

Requesting Clinician (Full Name)		**Ward/Clinic**	
Email address (For Report)			
Signature			
TEST REQUESTED	TRIO WES ☐	SINGLETON CUSTOM PANEL ☐ DETAILS OF PANEL/GENES:	
I confirm that informed consent has been obtained for all family members being tested and the possibility of incidental findings has been discussed - please select one of the following			
Patient **CONSENTS** to receive incidental findings			☐
Patient **DOES NOT CONSENT** to receive incidental findings			☐

Description of Clinical Features Please list the patients clinical features using HPO terms where possible (see https://hpo.jax.org/).	**Family History / Pedigree** Please include information about health problems in relatives and relationships to other people, including disease status and age of onset. Include details about miscarriages and stillbirths. If it is indicated below that parents are affected, please describe the phenotype relative to the child.

Previous Genetic Testing – Please include previous tests ordered and results. Where possible, reports should also be provided.

Consanguinity? If yes, please provide details.	

Samples

PROBAND, **MATERNAL**, and **PATERNAL** details are required. Please ensure names are included on pedigree.

SURNAME	FORENAME	DoB	NHS NUMBER	RELATION TO INDEX PATIENT	PHENOTYPE	SEX
				PATIENT	AFFECTED ☐ UNAFFECTE ☐	
				MOTHER	AFFECTED ☐ UNAFFECTE ☐	
				FATHER	AFFECTED ☐ UNAFFECTE ☐	

******Please note any remaining sample is to be returned to AWMGS on a monthly basis*******

VUS re-evaluation program – please select one of the following	
Patient **CONSENTS** to the VUS re-evaluation program	☐
Patient **DOES NOT CONSENT** to the VUS re-evaluation program	☐
For further information please visit the following - https://www.cegat.de/en/diagnostics/vus-reevaluation/	

Copies of report sent to (quoting AWMGS lab number):

Requesting Clinician(1):

Requesting Clinician(2):

Requesting Laboratory: **All Wales Molecular Genetics Laboratory Service**
Institute of Medical Genetics
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW

AWMGS Admin team: **Pt-lhb.admin-genetics@nhs.net**

*******PLEASE NOTE: Our IT policies prohibit the use of any email other than @nhs.net accounts as a means of accepting patient reports. Please send by post, FAX or to an @nhs.net email address*******

Invoice ONLY (quoting AWMGS lab number):

CAV Accounts Payable: **Finance Department**
University Hospital of Wales
Cardiff
CF14 4XW

PLEASE ONLY EMAIL INVOICES TO: NWSSP.APCAV@wales .nhs.uk

AND

accounts.payable2@wales.nhs.uk

*******DO NOT SEND REPORT TO FINANCE DEPARTMENT*******