

Data Quality Reminder - Cytogenetics Referral Card

Referral Card Completion Guide

For operational and CPA (UK) Ltd accreditation requirements the laboratory requires all data requested on the referral card. Compliance ensures appropriate testing and the reporting of results to the appropriate clinical staff. SEE SEPARATE ADVICE FOR MOL. GENETICS / DNA REFERRALS.

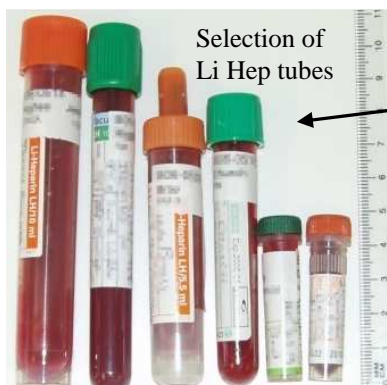
PLEASE COLLECT BLOOD SAMPLES INTO:

LITHIUM HEPARIN

REMEMBER THAT UNDER H&S REGULATIONS YOU ARE REQUIRED TO DECLARE HIGH INFECTION RISKS!

REMEMBER PATIENT CONFIDENTIALITY AND SAFETY. Ensure that the details on this card are not visible in transit. Package the card and sample to prevent damage / leakage and infection risk in transit. See our web site for further guidance.

Please provide **ALL** patient data requested in this upper section. Include the patient's postcode in the address. If labels are used, ensure **ALL** requested details are provided.



Further details about tests, consent issues, sample and media requirements and the packaging and transportation of samples appear on the reverse of the card.

Surname		TICK IF PRIVATE <input type="checkbox"/>	
Other Names		Sex (M/F)	
Address		Date of Birth	
(inc. Postcode)		VIRAL HEPATITIS B ? YES / NO OTHER HIGH RISK INFECTION ? YES / NO	
HOSPITAL		NHS Number	
Unit Number		Any Previous Cytogenetic YES / NO Investigations ?	
Ward / Clinic		Give Details:	
Consultant		Cytogenetics For Lab use only 	
SPECIMEN			
Sample should be sent to the laboratory as soon as is practicably possible, but may be stored overnight at +4°C. Please see reverse of card for advice on transport vessels, culture media, replacement cards and consent.			
Please tick if the patient or guardian does not want cellular material to be stored after testing <input type="checkbox"/>			
CLINICAL DETAILS (PLEASE) Include OBSTETRIC HISTORY where relevant. Is patient currently pregnant?			
Please use this space to record relevant clinical information and, if known, the specific test required. Remember to include any relevant family history. This information helps us focus our testing methods. Also indicate here details of any individuals requiring copy reports.			
Date sample taken:		Signature:	
AT AMNIOCENTESIS / CVB L.M.P.		GRAVIDA AGE BY SCAN PARA HUSBAND / PARTNER D.O.B.	
Cheshire & Merseyside Regional Genetics Laboratory Liverpool Women's NHS Foundation Trust Crown Street Liverpool L8 7SS Tel: 0151-702-4229			

NB. The lab offers a regional service - DO NOT ASSUME WE KNOW THE REFERRING DEPARTMENT / HOSPITAL.

Tick here for Private Referrals

Indicate here previous tests on this individual or close family members include Lab Nos if known.

Please tick if patient / guardian has explicitly not consented for unused material to be stored for laboratory Quality Assurance purposes only.

Record here the date that the sample was taken. Also, remember to sign the card.

Please provide this additional information for prenatal diagnosis referrals

For further information visit our web site at <http://www.lwh.me.uk/html/cytogenetics.php> or contact the laboratory Tel: 0151 702 4229.