

Data Quality Reminder - Mol. Gen. (DNA) Referral Card

Referral Card Completion Guide

For operational and CPA (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 CYTOGENETICS REFERRALS.

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.

BLOOD SAMPLES TO BE COLLECTED IN EDTA PLEASE!
(Usually pink/ purple-topped)

Please provide **ALL** patient data requested in this upper section. NB. Provide the NHS number, if known, and include the patient's postcode in the address. If labels are used, ensure **ALL** requested details are provided.

Regional Molecular Genetics Laboratory – Liverpool Women’s Hospital

PATIENT DETAILS (please fill in all details or use patient label + state hospital)		LAB USE ONLY	
Surname	Hosp. No:	LAB. NO.	
First name	NHS No:	Date booked in	
D.O.B.	Sex M/F	Consultant: (full name)	
Address inc POST CODE	Dept.	Hospital	Sample type
	Sample taken by:	Date taken:	
	Date taken:	Results to:	
Urgent Request <input type="checkbox"/>	(If yes please contact the lab)		
DISEASE/TESTS REQUIRED – Please give brief clinical details and full family history (if any) Please state clearly what tests are required or if sample is for DNA storage only		STATUS (Please tick) <input type="checkbox"/> Affected <input type="checkbox"/> At risk/predictive test <input type="checkbox"/> Obligate carrier <input type="checkbox"/> ?Carrier (with family history) <input type="checkbox"/> ?Carrier (no family history) <input type="checkbox"/> Prenatal diagnosis <input type="checkbox"/> Unaffected relative <input type="checkbox"/> For research	
Consent (see overleaf) Please tick if the patient does not want the remainder of their DNA/RNA to be stored in the laboratory <input type="checkbox"/>			
REQUEST FOR MOLECULAR GENETIC STUDIES – EDTA BLOOD SAMPLE (See Overleaf For Further Details)			

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



Tick the appropriate description of the Patient/ Testing status.

Please tick if patient / guardian has explicitly requested that unused material is not stored for Quality Assurance purposes only.

Tick here if request is for **URGENT** testing

For traceability and quality control purposes we need to know the referrer, referral centre, date of sample collection and the person taking the sample. Be sure to tell us to whom the results should be sent.

Please use this space to record relevant clinical information and the specific test required. Remember to include any relevant family history and any laboratory references for previous tests on this patient or other family members. This information helps us focus our testing methods. Also indicate here details of any individuals requiring copy reports.

For further information, **see reverse of card**, visit our web site at http://www.lwh.me.uk/html/molecular_gen.php , or contact the laboratory Tel: 0151 702 4228. Send packaged samples to: Regional Molecular Genetics Laboratory, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS.