

Surname TICK IF PRIVATE

Other Names Sex M/F

Address Date of Birth

HOSPITAL
 Unit Number
 Ward/Clinic
 Consultant
 SPECIMEN

Blood samples to be sent in lithium heparin tubes.

VIRAL HEPATITIS B? YES/NO
 ANY OTHER HIGH RISK INFECTION? YES/NO

Any previous cytogenetic investigations? YES/NO
 Give Details:

MED/01.1808 (Rev.) 12.05

Cytogenetics
 For Lab use only



Analyst:
 Category:
 Sample QA:
 Priority:
 FISH:

SPECIMENS TO BE SENT TO:
 Merseyside & Cheshire
 Regional Genetics Laboratory
 Liverpool Women's Hospital
 Crown Street
 Liverpool
 L8 7SS
 Tel: 0151-702 4229

CLINICAL DETAILS (PLEASE PRINT)

Include OBSTETRIC HISTORY where relevant. Is patient currently pregnant?

Tick if consent for storage not obtained

Date..... Signature.....

AT AMNIOCENTESIS/CVB GRAVIDA PARA
L.M.P. AGE BY SCAN HUSBAND/PARTNER D.O.B.

Please complete all elements of the request card. Affixing a self-adhesive label containing patient information is acceptable.

To avoid unnecessary follow-up calls for missing information, please ensure that the following minimum data is provided.

- Patient First Name
- Patient Last Name
- Date of Birth
- Address (inc Postcode)
- Unit number/ NHS number
- Clinical Information
- Test(s) required
- Referring Consultant
- Referring Unit details
- Date of sampling
- Indication if consent to store clinical material is declined.