

Data Quality Reminder - Cytogenetics Referral Card

Referral Card Completion Guide

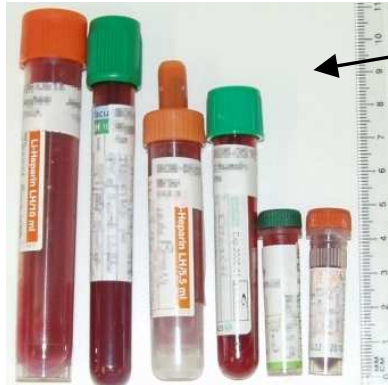
For operational and CPA (UK) Ltd accreditation requirements the laboratory requires all data requested on the referral card. Compliance ensures appropriate testing and the reporting of results to the appropriate clinical staff. SEE SEPARATE ADVICE FOR MOL. GENETICS / DNA REFERRALS.

BLOOD SAMPLES TO BE COLLECTED INTO LITHIUM HEPARIN PLEASE.

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** details are provided.



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

Surname		TICK IF PRIVATE <input type="checkbox"/>
Other Names		Sex M/F
Address		Date of Birth
HOSPITAL Unit Number Ward/Clinic Consultant SPECIMEN		VIRAL HEPATITIS B? YES/NO ANY OTHER HIGH RISK INFECTION? YES/NO Any previous cytogenetic investigations? YES/NO Give Details:
Blood samples to be sent in lithium heparin tubes.		
CLINICAL DETAILS (PLEASE PRINT) Include OBSTETRIC HISTORY where relevant. Is patient currently pregnant?		
Tick if consent for storage not obtained <input type="checkbox"/>		
Date..... Signature.....		
AT AMNIOCENTESIS/CVB	GRAVIDA	PARA
L.M.P.	AGE BY SCAN	HUSBAND/PARTNER D.O.B.

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

MED/01-1068 (Rev.) 12-95

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

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 requested that unused material is not stored for laboratory Quality Assurance purposes only.

Please provide this additional information for prenatal diagnosis referrals

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.

For further information visit our web site at http://www.lwh.org.uk/clinical_services/genetics/cytogenetics/index.html or contact the laboratory Tel: 0151 702 4229.

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Version: 1.1	Approved: PJH	Date: February 2006	Review Due: February 2009