

NHS GRAMPIAN MEDICAL GENETICS SERVICE - REQUEST FOR GENETIC ANALYSIS

North East Scotland Genetics Service, NHS Grampian, Polwarth Building, Foresterhill, Aberdeen AB25 2ZD.

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Essential Patient Demographics (Patient label can be used)		
Forename:	Surname:	
CHI No.:	Date of Birth:	Male / Female <small>(Circle as appropriate)</small>
Address (must include postcode):		
		Postcode:
Pedigree No. (if known):	Genetics Reference No. (if known):	
Essential Referrer Details		
Referring Clinician(s):	Address for Report:	
Copy to:		
Ward / Department / Practice:		
Email address:		
Telephone no.:		
Essential Sample Information		
Sample Type:	Date Taken:	Time Taken:
High Risk: YES / NO If yes, please state risk _____ Notify lab in advance if high risk	Urgent analysis required: YES / NO	DNA / Molecular Genetics only Storage only: YES / NO
Test(s) requested:		
Reason for referral & relevant clinical information:		
CONSENT: It is the responsibility of the referring clinician to obtain informed consent from the patient / carer for the test and for the sample to be stored for future diagnostic testing.		
Signature of referring clinician: _____ Print name: _____		
Incomplete or illegible referral forms may lead to sample rejection and a delay in testing Please see www.nhsgrampian.org/medicalgenetics for sample & transport requirements		