NHS
London South
NHS Genomic Laboratory Hub

# MOLECULAR MINIMAL RESIDUAL DISEASE MONITORING REQUEST FORM FOR NON-TRIAL SAMPLES

Request forms from: www.londonsouthgenomics.nhs.uk

Please complete electronically if possible. Incomplete forms will result in delays or rejection.

## PATIENT DETAILS

**Last name:**

**First name:**

**DOB:**

**NHS number:**

**Originating Lab No:**

**Purchase Order No:**

**Non-NHSE Funded i.e. Research/Private** ☐ (please attach invoicing details)

## PATIENT ETHNICITY

| | |
|---|---|
| **White:** | British ☐ Irish ☐ Any Other White Background ☐ |
| **Mixed:** | White And Black Caribbean ☐<br>White And Black African ☐ White And Asian ☐<br>Any Other Mixed Background ☐ |
| **Asian or Asian British:** | Indian ☐ Pakistani ☐ Bangladeshi ☐<br>Any Other Asian Background ☐ |
| **Black or Black British:** | Caribbean ☐ African ☐<br>Any Other Black Background ☐ |
| **Other Ethnic Groups:** | Chinese ☐ Any Other Ethnic Group ☐ |
| **Not stated** ☐ | **Not Known** ☐ |

## Sample type

**Sample collection date and time**

**5ml Bone Marrow in EDTA** ☐ ____/____/____

**20ml Peripheral Blood in EDTA** ☐ ____/____/____

**Other (cDNA/gDNA/RNA/TRIzol/RLT)** – please specify: _____ ☐ PB ☐ BM ____/____/____

## Baseline data (*not required if previous patient samples have been analysed and reported*)

Analysed before? Yes ☐ No ☐ *please provide details below*

Date of diagnosis: _____ Karyotype: _____

NPM1: Yes ☐ No ☐ FLT3-ITD: Yes ☐ No ☐ FLT3-TKD: Yes ☐ No ☐

Name of local molecular lab:_____ (*for enquiries or retrieval of diagnostic material if necessary*)

## Routine sample information

☐ New diagnosis ☐ On treatment (post course: _____ ) ☐ Post transplant (day: _____ )

☐ Follow-up (month: _____ ) ☐ Relapse ☐ Other _____

## Test required

☐ Molecular MRD Target _____ (*please refer to the GLH website for a list of targets*)

☐ Other _____ (*please discuss with laboratory **prior** to request e.g. RNAseq/ddPCR/NGS*)

## CLINICIAN DETAILS

**Requesting Clinician / Consultant:**
**Hospital:**
**Referring lab (if different):**
**Clinician e-mail:**
**Contact:** Phone / Bleep
**Signature:** _____ **Date:** ____/____/____

**Main contact (if different from responsible clinician/consultant):**
**Contact e-mail:**

**Transplant Centre (if relevant):**
**Contact at centre:**
**Contact e-mail:**

**Please send all samples to:**
**Molecular Oncology Diagnostics Unit - Viapath**
**4th Floor Southwark Wing, Guy's Hospital**
**Great Maze Pond, London SE1 9RT**

**Lab contact:** 020 7188 7188 ext 51060
**Email:** gst-tr.amlmrd@nhs.net

For clinical enquiries please email: richarddillon@nhs.net

**Please ensure tubes are clearly labelled peripheral blood (pb) or bone marrow (bm).**
**In submitting this sample, the clinician confirms that consent has been obtained for testing and storage.**

**LAB USE ONLY** **Date sample received:** _____ **Time sample received:** _____