TDL GENETICS
60 Whitfield Street
London W1T 4EU
Tel: 020 7307 7409
Fax: 020 7307 7350
Email: tdlgenetics@tdlpathology.com

Doctor _____
Address _____
_____
_____
Tel _____ Fax _____

Additional copy of results to:

Priority status _____

TAP1115/09-02-10 /V4

SURNAME																					M/F	DOB or AGE	Patient Ref. No.	Gestation
FORENAME																TITLE								

Clinical Details – include reason for test request and family history
(Please complete this box – details are crucial for analysis and interpretation)

PRENATAL NT: Risk: Abnormal U/S Findings:
No of fetuses:

PRENATAL ASSAYS

- **Amnio PCR** ☐
- **Amnio Culture** ☐
- **Amnio PCR & Culture** ☐
- **∝FP** ☐
- **CVS PCR** ☐
- **CVS Culture** ☐
- **CVS PCR & Culture** ☐
- **Chromosome Analysis Products of Conception** ☐
- **Telomeres & microdeletions by MLPA** ☐

Please *ensure* options* below are completed.

***fetal sex to be reported**
Yes ☐ **No** ☐

***p.F508del Cystic Fibrosis**
Yes ☐ **No** ☐

***Fee for these options is included in test price.**

POSTNATAL ASSAYS

- **Chromosome Analysis Blood** ☐
- **Chromosome Analysis Slide** ☐
- **Fragile X Molecular Studies** ☐
- **Chromosome Analysis of Solid Tissue** ☐

MLPA Probe

- **Di George/VCFS** ☐
- **Miller-Dieker** ☐
- **Prader-Willi/Angelman** ☐
- **Williams** ☐
- **Wolf-Hirschhorn** ☐
- **Smith-Magenis** ☐
- **Duchenne Muscular Dystrophy** ☐
- **Spinal Muscular Atrophy** ☐
- **Telomeres** ☐
- **Mental Retardation Panel** ☐

DNA ASSAYS

- **CF (32 Mutations)** ☐
- **Poly T analysis** ☐
- **Haemochromatosis mutations** ☐
- **Y chromosome deletion** ☐
- **Paternity Testing** ☐
- **Uniparental Disomy** ☐
- **Factor II Prothrombin** ☐
- **Factor V Leiden** ☐
- **MTHFR** ☐
- **Array CGH** ☐
- **Alpha – 1 – antitrypsin** ☐
- **Zygosity testing** ☐
- **Apo E Genotype** ☐
- **HLA Tissue Typing** ☐
  (A,B,Cw,DR,DQ Coeliac/Narcolepsy)
  Please specify _____
- **HLA B27** ☐
- **DNA extraction and storage** ☐
  For 3 years unless otherwise stated
  _____

PROFILES

- **Male Genetic Reproductive Profile** ☐
  Y Chromosome Microdeletion DNA Studies / Cystic Fibrosis Carrier Screen / Chromosome analysis
- **Iron Overload Profile** ☐
  Iron / Total Iron Binding Capacity / Ferritin / Haemochromatosis mutation
- **Ashkenazi Jewish Carrier Screen (includes all below)** ☐
  Canavan Disease / Familial Dysautonomia / Fanconi anaemia / Tay Sachs / Bloom Syndrome / Niemann Pick Disease / Mucolipidosis IV / Glycogen Storage Disease / CF (7 mutations)
- **Tay Sachs Carrier Screen (single test)** ☐
- **Gaucher Disease Carrier Screen** ☐

Other test:

Patients address and telephone number
Address _____
_____
Town/City _____ Postcode _____
Contact telephone number _____

Fee to be paid by: Dr ☐ Patient ☐ Other ☐ If 'Other' please provide address
_____
_____
_____ Postcode _____
Signature _____ Date ___/___/___
Tick if a Letter of Guarantee is required ☐

Laboratory notes:

For Practice Use Only:

EDTA	LH	AMNIO	CVS	POC	OTHERS

Sample Date _____ Sample Time _____

For Laboratory Use Only:

EDTA	LH	AMNIO	CVS	POC	OTHERS

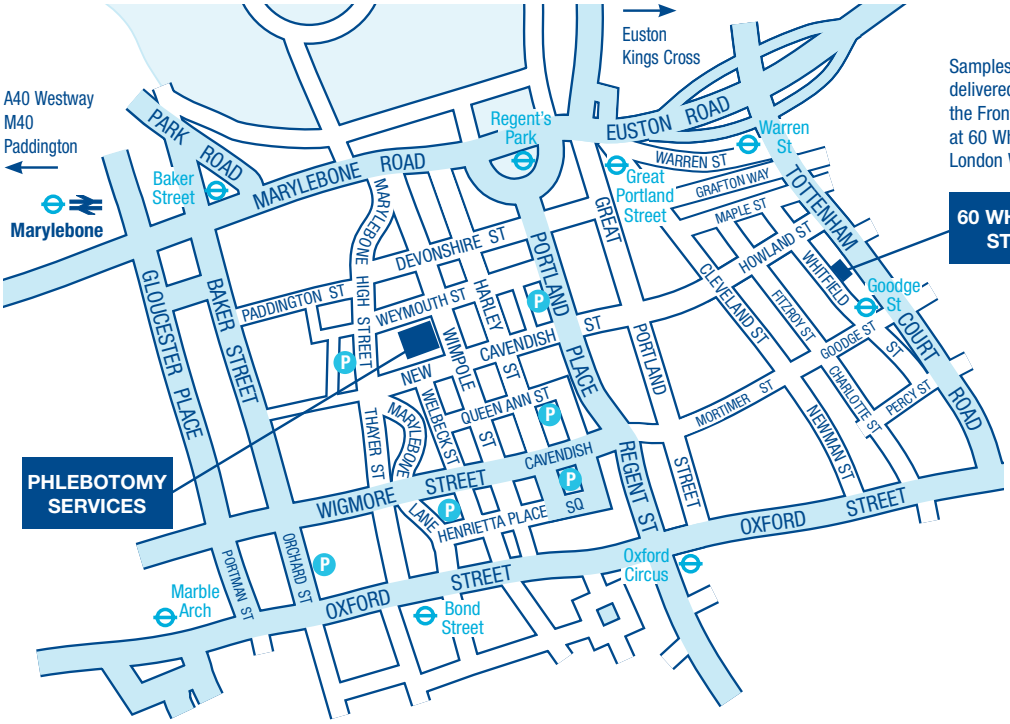
Analysis _____

Date/Time received:

For further test information or sample requirements please refer to Laboratory Guide or contact Dr Lisa Levett on 020 7307 7409.

Patient Consent: The laboratory does not seek to confirm that informed consent has been obtained for tests requested, unless otherwise stated in the laboratory guide. It is the responsibility of the referring clinicians to ensure appropriate consent has been obtained.

TDL GENETICS



Samples may be delivered by hand to the Front Entrance at 60 Whitfield Street London W1T 4EU

FOR LABORATORY USE ONLY

Notes:

TDL GENETICS

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Tel: 020 7307 7409 Fax: 020 7307 7350
E-mail: tdlgenetics@tdlpathology.com

CONSENT FORM

PATIENT OR GUARDIAN

Please cross-out where applicable.

I consent / do not consent to be tested for the genetic test/tests which have been explained to me.

I consent / do not consent for the results of this test to be available to assist in testing other family members.

I consent / do not consent for DNA from this sample to be stored.

I consent / do not consent for DNA to be used anonymously for relevant research.

Signed _____

Date ____ /____ /____

DOCTOR

I have explained the purpose of obtaining a blood or tissue sample for genetic testing.

Signed

Date ____ /____ /____

This consent form is for use with diagnostic testing. It is important to think through the implications of genetic testing for other family members. Certain family studies may reveal information regarding paternity. We strongly recommend genetic counselling for predictive testing in disorders such as Huntington's Disease or inherited cancers. Please contact our Consultant if you have queries about consent or counselling issues.