


Genomic Medicine Service	RARE AND INHERITED DISEASES	
Whole Genome Sequencing (WGS) Test Request		
PLEASE DO NOT USE FOR NON-WGS TESTS		

Requesting organisation:
GLH laboratory:

Proband's first name	Life status <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Ethnicity
Proband's last name	Family test <input type="checkbox"/> Singleton <input type="checkbox"/> Trio <input type="checkbox"/> Other (provide number):	
Date of birth (dd/mm/yyyy)	Hospital number	Relevant clinical information <i>Please include any previous molecular testing with date(s) and any other pertinent clinical information</i>
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <small>Please state in clinical information box if karyotypic and/or phenotypic sex differ from given gender</small>		
Postcode		
NHS number		
Reason NHS Number not available: <input type="checkbox"/> Patient not eligible for NHS number (e.g. foreign national) <input type="checkbox"/> Other (please provide reason):		

Test request		
Clinically urgent <input type="checkbox"/> There is currently no urgent WGS pathway, however it may be possible to prioritise some cases. Please provide details of why this referral is considered urgent.	Test Directory Clinical Indication & code (reason for testing)	
Proband's age of onset years months		
Additional panel(s) (if relevant; mandatory for R89) <small>(use panels with panel type 'GMS Rare Disease Virtual' - http://panelapp.genomicsengland.co.uk)</small>	Disease penetrance <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete	Specific rare or inherited diseases that are suspected or have been confirmed

Family members to be tested (not required for proband only referrals)								
First name	Last name	Date of birth	NHS Number (or postcode if not known)	Gender	Deceased	Status	Ethnicity	Relationship to proband

Samples being sent to GLH DNA extraction lab (only required if also using this form for sample collection)							
First name	Last name	Date of birth	Sample ID	Collection date / time	Sample type	Sample volume	Comments

Responsible clinician / consultant	Main contact (if different from responsible clinician/consultant)
Name:	Name:
Department address:	Department address:
Phone:	Phone:
Email:	Email:

- I have attached a copy of the Record of Discussion form for all individuals
- Patient conversation taken place; Record of Discussion form to follow

