



PAEDIATRIC CANCER

Specialist Integrated Haemato-Oncology & Malignancy Service -
Acquired Genomics (SIHMDS.AG)
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Standard of Care Testing
PLEASE USE FOR NON-WGS TESTS

Patient first name	Ethnicity
Patient last name	Test Directory Clinical Indication
Date of birth (dd/mm/yyyy) Hospital number	Further clinical details
Postcode	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
NHS number	<input type="checkbox"/>
Date sample taken:	
Histopathology reference number:	
Presentation status	
Tumour content (%)	<input type="checkbox"/> First diagnosis <input type="checkbox"/> Recurrence/relapse <input type="checkbox"/> Unknown <input type="checkbox"/> Other (details below)
Additional tumour info	
Molecular test(s) requested	Cytogenetic test(s) requested
<input type="checkbox"/> RNA fusion panel <input type="checkbox"/> Targeted DNA NGS panel <input type="checkbox"/> SNP array <input type="checkbox"/> Methylation array (neuropathology classifier)	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH
Sample(s) for molecular testing	Sample(s) for cytogenetic testing
<input type="checkbox"/> Bone marrow (EDTA) <input type="checkbox"/> Peripheral blood (EDTA) <input type="checkbox"/> Frozen tissue <input type="checkbox"/> FFPE tissue (5-10µM)	<input type="checkbox"/> Peripheral blood (lithium heparin) <input type="checkbox"/> Bone marrow (lithium heparin) <input type="checkbox"/> FFPE sections (2-4µM) <input type="checkbox"/> Other (details below)
Referrer information	
Name: Dept: Hospital: Phone: Email:	Additional information (if required)
In submitting the sample the referring clinician confirms that consent for testing and possible storage has been obtained	