Please contact the Testing Laboratory by telephone or e-mail BEFORE sending any samples
North Thames GLH Tel: 0207 762 6886 Email: gos-tr.londonnorthglhrapidsequencing@nhs.net
Central & South GLH Tel: 0121 335 8027 Email: bwc.rglprenatalexome@nhs.net

Genomic Medicine Service
National Genomic Test Directory Clinical Indication R21 Rapid Prenatal Exome Sequencing Test Request

SECTION 1 - To be completed by referring fetal medicine unit

Before completing this form please confirm that testing has been discussed with and agreed by clinical genetics. Email addresses must be provided for the responsible FMU clinician and clinical geneticist. ☐

CONSENT: Receipt of samples for testing assumes that **informed consent** has been obtained for all family members being tested and the possibility of incidental findings has been discussed. The Record of Discussion form must be completed and saved in the patients notes.

Date of form completion:

Maternal and pregnancy details

Surname:	Date of birth: dd/mm/yyyy	Ethnicity:
Forename:	Gestation: weeks days	Fetal Gender (by scan): ☐ Male ☐ Female ☐ Undetermined
Hospital number:	Paternal sample available?: ☐ Yes ☐ No	Consanguinity: ☐ Yes ☐ No ☐ Unknown
NHS number (or postcode if not known)	Additional information: e.g. please specify if IVF pregnancy/gamete donor etc.	

Paternal details:

Surname	Forename	Date of birth dd/mm/yyyy	NHS number	Ethnicity

Clinical details:

Please list main clinical features in fetus and **attach scan report(s):**
Growth charts must also be included if applicable.

Relevant family history or obstetric history: ☐ Yes ☐ No If yes, please give details

Relevant clinical features in parents: ☐ Yes ☐ No If yes, please give details

Referrer details:

Responsible FMU clinician: Forename: Surname: Hospital:	Email address for report: (nhs.net or equivalent secure email) Telephone number:
Clinical geneticist: Forename: Surname: Hospital:	Email address for report: (nhs.net or equivalent secure email) Telephone number:

Clinical genetics departmental shared email address:
(nhs.net or equivalent secure email)

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SECTION 2 - To be completed by referring laboratory

Please confirm with which Laboratory this test has been discussed:
☐ North Thames GLH ☐ West Midlands, Oxford and Wessex GLH

Fetal DNA extracted from:	☐ Amniocytes	☐ Cultured cells - amniocytes	Date of invasive test: dd/mm/yyyy
	☐ CVS	☐ Cultured cells - CVS	
	☐ Fetal blood	☐ Cultured cells - fetal blood	

Other genetic testing done or in progress: **Please attach reports**	qfPCR: ☐ Yes ☐ In progress	Result:
	Microarray: ☐ Yes ☐ No ☐ In progress	Result:
	Other (specify genes/panels):	Result:

Required samples: Fetal DNA, Maternal DNA, Paternal DNA (Paternal sample can be omitted if not obtainable)
Please email the completed form to the Testing Laboratory BEFORE sending any samples.

Please send at least 100ng of DNA per individual to the appropriate laboratory:
North Thames GLH, Specimen Reception Level 5 Barclay House, 37 Queen Square, London WC1N 3BH
Central & South GLH, DNA Laboratory, Birmingham Women's Hospital, Edgbaston, Birmingham, B15 2TG

Laboratory contact: Forename: Surname: Lab:	Email address for report: (nhs.net or equivalent secure email) Telephone number:

CHECKLIST - Before sending please ensure the following are included with this request form

- ☐ Fetal DNA sample
- ☐ Maternal DNA sample
- ☐ Paternal DNA sample (unless no way to obtain this)
- ☐ Copy of scan report(s), including growth charts if applicable
- ☐ Copy of genetic report(s): qfPCR plus any other tests done