


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

<b>Requesting organisation:</b>
<b>GLH laboratory:</b>

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):		

<b>Test request</b>		
<b>Clinically urgent</b> <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; <b>mandatory for R89</b> ) <small>(use panels with panel type 'GMS Rare Disease Virtual' - <a href="http://panelapp.genomicsengland.co.uk">http://panelapp.genomicsengland.co.uk</a>)</small>	Disease penetrance <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete	Specific rare or inherited diseases that are suspected or have been confirmed

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

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

<b>Responsible clinician / consultant</b>	<b>Main contact (if different from responsible clinician/consultant)</b>
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

