

All fields are mandatory. Illegible, unclear or incomplete forms will result in delays or rejection.

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CONSENT STATEMENT: It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample may be stored for future diagnostic testing. In signing this form the clinician has obtained consent for testing, storage and for the use of this sample and the information gathered from it to be shared with members of the donor's family through their health professionals (if appropriate). The patient should be advised that the sample may be used anonymously for quality assurance and training purposes. **If the patient does not wish information to be shared please write this clearly in the clinical summary box.**

PATIENT DEMOGRAPHICS		PATIENT ETHNICITY	
First name:		White:	British <input type="checkbox"/> Irish <input type="checkbox"/> Any Other White Background <input type="checkbox"/>
Last name:		Mixed:	White And Black Caribbean <input type="checkbox"/> White And Black African <input type="checkbox"/> White And Asian <input type="checkbox"/> Any Other Mixed Background <input type="checkbox"/>
DOB:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	Asian or Asian British:	Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background <input type="checkbox"/>
NHS number:		Black or Black British:	Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any Other Black Background <input type="checkbox"/>
Hospital no:	Family ref no:	Other Ethnic Groups:	Chinese <input type="checkbox"/> Any Other Ethnic Group <input type="checkbox"/> (please specify: _____)
Postcode:	Life status: Alive <input type="checkbox"/> Deceased <input type="checkbox"/>	Not stated <input type="checkbox"/>	Not Known <input type="checkbox"/>
Non-NHSE funded (please attach invoicing details): <input type="checkbox"/>			

CLINICAL INDICATIONS	
Segmental overgrowth disorders R110 (only germline mutations) <input type="checkbox"/>	Cutaneous photosensitivity with a likely genetic cause R237 <input type="checkbox"/>
Ectodermal dysplasia R163 <input type="checkbox"/>	Incontinentia pigmenti R239 <input type="checkbox"/>
Epidermolysis bullosa and congenital skin fragility R164 <input type="checkbox"/>	Epidermodysplasia verruciformis R255 <input type="checkbox"/>
Ichthyosis and erythrokeratoderma R165 <input type="checkbox"/>	Vascular skin disorders R326 (only germline mutations) <input type="checkbox"/>
Palmoplantar keratodermas R166 <input type="checkbox"/>	Rare genetic inflammatory skin disorders R332 <input type="checkbox"/>
Autosomal recessive primary hypertrophic osteoarthropathy R167 <input type="checkbox"/>	Other <input type="checkbox"/>
Xeroderma pigmentosum, Trichothiodystrophy or Cockayne syndrome R227 <input type="checkbox"/>	
Multiple monogenic benign skin tumours R230 <input type="checkbox"/>	
Pigmentary skin disorders R236 <input type="checkbox"/>	

CLINICAL INFORMATION AND FAMILY HISTORY	
Please include relevant family history, details of any consanguinity and provisional diagnosis. PLEASE NOTE TESTING WILL NOT COMMENCE UNTIL FULL CLINICAL INFORMATION IS PROVIDED.	
For familial cases, please include a pedigree with the patient clearly marked:	
Affected <input type="checkbox"/> Unaffected <input type="checkbox"/>	CLINICALLY URGENT? <input type="checkbox"/> Reason for urgency: _____

Sample(s) Skin: Michel's Medium <input type="checkbox"/> Skin: EM Fixative <input type="checkbox"/> Skin: RNA Later <input type="checkbox"/> Blood (in EDTA tube) <input type="checkbox"/> DNA <input type="checkbox"/> Saliva <input type="checkbox"/> ELISA <input type="checkbox"/>	<u>For lab reference use only</u> 	Skin biopsy details: Biopsy site: _____ Shave <input type="checkbox"/> Punch <input type="checkbox"/> Ellipse <input type="checkbox"/> Lesional <input type="checkbox"/> Peri-lesional <input type="checkbox"/> Non-lesional <input type="checkbox"/> Rubbed skin: Yes <input type="checkbox"/> No <input type="checkbox"/> Date & time of sample(s): _____ Pedigree number: _____
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CLINICIAN DETAILS	
Requesting clinician / consultant Name: Hospital & department: NHS email: Phone:	Responsible clinician / consultant (<i>if different</i>) Name: Hospital & department: NHS email: Phone:

Note: Please ensure the latest version of this request form is used, found on our website: www.southeastgenomics.nhs.uk