NHS
South East
Genomic Laboratory Hub

SOUTH EAST MOLECULAR ctDNA REQUEST FORM

Request forms from: www.southeastgenomics.nhs.uk

Please send all samples to:
Cancer Genetics, 4th floor Southwark Wing, Guy's Hospital, SE1 9RT

For queries, please contact:
seglhsomaticcancer@synnovis.co.uk

For sample collection guidance, please visit:
https://southeastgenomics.nhs.uk/

All fields are mandatory. Illegible, unclear or incomplete forms will result in delays or rejection.
This page is to be printed.

PATIENT DEMOGRAPHICS	
First name:	
Last name:	
DOB:	**Gender:** Male ☐ Female ☐ Other ☐
NHS number:	
Hospital no:	**Postcode:**
Purchase Order no.:	
Non-NHSE funded i.e. Research / Private (attach invoicing details) ☐	
Ethnicity:	

FOR CANCER GENETICS USE

In submitting this form, the requester confirms that informed consent has been obtained from the patient/carer for testing and storage. Testing may be performed at Synnovis, any other U.K. laboratory or by other international laboratories where necessary. The requester has confirmed that the patient understands that somatic (acquired) testing by ctDNA analysis may demonstrate secondary germline (heritable) findings, or evidence of somatic events associated with malignancies incidental to the indicated diagnosis. The patient should be advised that the sample may be used anonymously for quality assurance and training purposes.

REFERRER DETAILS

Requester:

Hospital & Department:

Email for contact

Phone:

Signature: **Date:** ____/____/____

Report recipient details (email)

Additional recipients (email)

TEST DIRECTORY CLINICAL INDICATION & CODE (for multi-target NGS panel testing)

M / Test Code: MANDATORY

SAMPLE / CLINICAL DETAILS

Date sample taken:

Time sample taken:

Taken by:

Tracking ID:

Original or suspected diagnosis:

Date of diagnosis:

Confirmed: Yes ☐ No ☐

Tumour type / histological subtype:

CURRENT THERAPY
None ☐ Targeted ☐ Chemotherapy ☐ Other ☐
Therapy detail (incl # of cycles and duration)

Mandatory for M3.13 only

☐ ER-positive HER2-negative breast cancer

☐ Progressed after endocrine & CDK4/6 inhibitor (specify duration of treatment above)

Prior testing (complete as appropriate)

Tissue ☐ Date:

ctDNA ☐ Date:

Germline ☐

Please list specific variants detected in any prior genetic testing

Prior variant detection (complete as appropriate)

	AKT1	*ALK*	*BRAF*	*EGFR*	*ERBB2*	*ESR1*	*KRAS*	*MET*	*PIK3CA*	*PTEN*	*RET*	*ROS1*
DETECTED	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NOT Detected	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NOT Tested	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional clinical information to facilitate reporting
Please provide detail regarding previous tumours, and pertinent additional information regarding molecular testing and treatment. Please attach a copy of histology, IHC, and cyto/genetic reports