

## South East Genomic Laboratory Hub

## REQUEST FORM

Request forms from: [www.southeastgenomics.nhs.uk](http://www.southeastgenomics.nhs.uk)

For queries, please contact:  
[seglsomaticcancer@synnovis.co.uk](mailto:seglsomaticcancer@synnovis.co.uk)

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

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

<b>PATIENT DEMOGRAPHICS</b>		<b>FOR CANCER GENETICS USE</b>										
First name:												
Last name:												
DOB:	Gender: Male    Female    Other											
NHS number:	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											
Hospital no:	Postcode:											
Purchase Order no.:												
Non-NHSE funded i.e. Research / Private (attach invoicing details) <input type="checkbox"/>												
Ethnicity:												

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.

<b>REFERRER DETAILS</b>  Requester:  Hospital & Department:  Email for contact:  Phone:  Signature: _____ Date: ___/___/___	Report recipient details (email)   Additional recipients (email)
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**TEST DIRECTORY CLINICAL INDICATION & CODE (for multi-target NGS panel testing)**

**M / Test Code:**  
MANDATORY

<b>SAMPLE / CLINICAL DETAILS</b>		<b>CURRENT THERAPY</b>	
Date sample taken:	Original or suspected diagnosis:	None <input type="checkbox"/>	Targeted <input type="checkbox"/>
Time sample taken:	Date of diagnosis:	Chemotherapy <input type="checkbox"/>	Other <input type="checkbox"/>
Taken by:	Confirmed:    Yes    No	Therapy detail (incl # of cycles and duration)	
Tracking ID:	Tumour type / histological subtype:	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

**Prior variant detection (complete as appropriate)**

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

**Please list specific variants detected in any prior genetic testing**

**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