

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.

| DATIENT | AOCDADUUCC | | | | | | | 7 |
|---|--|-------------------|---------------------|-------------------------|------------------|----------------------------------|---------------------------------|---|
| PATIENT DEMOGRAPHICS | | | | | | | | FOR CANCER GENETICS USE |
| First name: | | | | | | | | |
| Last name: | | | | | | | | |
| DOB: | | (| ende | r: Male | | Female | Other | |
| NHS number | : | | | | | | | |
| Hospital no: | | P | ostco | de: | | | | |
| Purchase Or | der no.: | | | | | | | |
| Non-NHSE fu | unded i.e. Researc | h / P | rivate | (attach | invo | oicing detail | s) 🗆 | |
| Ethnicity: | | | | | | | | |
| Synnovis, any (acquired) testing | other U.K. laboratory on the other U.K. laboratory of the U.K. laboratory of the U.K. laboratory of the | or by c ay den | other in nonstra | ternationa te second | al lab lary g | oratories whe germline (herit | re necessary. able) findings | m the patient/carer for testing and storage. Testing may be performed at The requester has confirmed that the patient understands that somatic , or evidence of somatic events associated with malignancies incidental to e |
| REFERRER DETAILS | | | | | | | Repor | t recipient details |
| Requester: Hospital & Department: E-mail (for contact and reports): Phone: Signature: Date: / / | | | | | | , | Additi | onal recipients |
| Signature. | | | _ Date | e: /_ | | . / | | |
| Date/time: Original diagnosis: Date: Confirmed: | | | | | | | | NT THERAPY □ Targeted □ Chemotherapy □ Other □ |
| Person: Yes No | | | | | | | Therap | - ' ' |
| Transport tracki | ng ID: Tumour type: | : | | | | | | |
| Histological subtype: | | | | | | | | tory for M3.13 (ESR1 for breast cancer) only sitive HER2-negative |
| TEST DIRECTORY | CLINICALINDICATION 8 | & CODI | E | | | | | Prior variant detection (complete as appropriate) |
| M Code: | | | | | | | Dotos | AKT1 ALK BRAF EGFR ERBB2 ESR1 KRAS MET PIK3CA PTEN RET ROS1 |
| Test Code: | | | | | | | Detec | etected |
| Prior testing | (complete as appropria | ate) | | | | | Not to | |
| Tissue | date/s: | | | | | | | e list specific variants detected in any prior genetic testing |
| ctDNA | date/s: | | | | | | | ,,, , , , , , , , , , , , , , , , , , , |
| Germline | | | | | | | | I |
| Please provide d | al information to facilit etail regarding previous orts where possible. | | | | t add | ditional informa | ation regarding | g molecular testing and treatment. Please attach a copy of histology, IHC, and |