

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

Proband's first name	Life status Alive    Deceased	Ethnicity																		
Proband's last name	Family test Singleton    Trio    Other (provide number):																			
Date of birth (dd/mm/yyyy)	Hospital number	<b>Relevant clinical information</b> <i>Please include any previous molecular testing with date(s) and any other pertinent clinical information</i>																		
Gender Male    Female    Other <small>Please state in clinical information box if karyotypic and/or phenotypic sex differ from given gender</small>																				
Postcode <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																				
NHS number <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																				
Reason NHS Number not available: Patient not eligible for NHS number (e.g. foreign national) Other (please provide reason):																				

Test request		
Clinically urgent	Test Directory Clinical Indication & code (reason for testing)	Proband's age of onset  <i>years    months</i>

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 Complete Incomplete	Specific rare or inherited diseases that are suspected or have been confirmed
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Family members to be tested (not required for proband only referrals)								
First name	Last name	Date of birth	NHS Number (or postcode if not known)	Gender	Deceased	Status	Ethnicity	Relationship to proband

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

Responsible clinician / consultant	Main contact (if different from responsible clinician/consultant)
Name: Department address:  Phone: Email:	Name: Department address:  Phone: 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

