

Molecular Pathology Request Form

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EGFR MUTATION TESTING ON CIRCULATING TUMOUR DNA

REQUESTING PHYSICIAN/ONCOLOGIST:

Name:			
Hospital Name and Address:			
Telephone:		Send report to:	

PATIENT DETAILS:

Surname:		Forename:	
CHI:		Date of Birth:	
Address (if CHI not available):			
Sex:	M / F	Date of sample collection:	
Priority:	Normal / Urgent	Time of sample collection:	

Please ensure all blood tubes are clearly labelled with the patient ID

REASON FOR REQUEST:

Diagnosis	<input type="checkbox"/>	Please specify: <input type="text"/>
Follow-up	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	

ADDITIONAL INFORMATION (OPTIONAL):

Current treatment:	
Known EGFR mutation(s):	

SPECIMEN REQUIREMENTS:

8.5 ml of blood in Roche Diagnostics CE-IVD CELL-FREE DNA COLLECTION TUBES (catalogue no. 07785666001 or contact the Molecular Pathology team). **Alternative blood tubes have not been validated and cannot be accepted for analysis. Check blood tube expiry date prior to use.**

Please invert gently 8-10 times immediately after sample collection.

Keep at ROOM TEMPERATURE. DO NOT REFRIGERATE.

Please send the specimen to Molecular Pathology at the above address.

All biological substances must be posted in packaging that complies with the carrier's packaging instructions such as Royal Mail Safebox. It is the responsibility of the sender to ensure all criteria for safe transport of biological materials are met.

Further information including the current version of this request form is available online at:

www.edinburghlabmed.co.uk/specialities/genescience/molecularpathology

FOR LABORATORY USE ONLY	
Date/time request received:	