Molecular Pathology Request Form

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REQUESTOR DETAILS:

Sending Department:			
Requesting Clinician:			
Report to be issued to (clinician/email address/location):			
Contact Telephone:		Email:	

PATIENT DETAILS:

Surname:		Forename:		
CHI (or Date of Birth):			Sex:	M ☐ F ☐
Address *(if known)*:				
Specimen type	Extracted DNA	Concentration		
Specimen Ref. No.:		Diagnosis:		
Sample collection date:		Priority:		Normal ☐ Urgent ☐

TEST REQUESTED:

☐	**AML IDH1**

Please send extracted DNA (minimum of 10ng) for testing.

***Please ensure contacts details of requesting clinician are included to enable results to be emailed directly ***