**Molecular Testing Request Form**

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| **Patient Details**  | **From:** |
|  |  |
| **Date Taken:**  | **Doctor’s Name:** |
| **Time Taken:** |

|  |
| --- |
| **Test Required: (Please select)** |
| FIP1L1-PDGFRα  |
| c-KIT d816v mutation  |

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| **Requirements:** |
| 20mls of peripheral blood and/or 2-3mls marrow |

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| **Clinical Details:** |  |
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| **Sample Type:** | **Peripheral Blood** | **Bone Marrow** |
|  |  |  |

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| **To:** | **Return to:** |
| Professor N CrossWessex Regional Genetics LaboratorySalisbury District HospitalSalisburyUnited Kingdom SP2 8BJ |  |