**Molecular Testing Request Form**

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

|  |
| --- |
| **Test Required:** |
| **Q-PCR PML-RARα** |

|  |
| --- |
| **Requirements:** |
| **First pull (2-3mls) of marrow plus 20-30mls of peripheral blood** |

|  |  |
| --- | --- |
| **Clinical Details:** |  |
|  | |

|  |  |  |
| --- | --- | --- |
| **Sample Type:** | **Peripheral Blood** | **Bone Marrow** |
|  |  |  |

|  |  |
| --- | --- |
| **To:** | **Return to:** |
| Dr Yvonne Morgan, Molecular Oncology Diagnostics Unit Clinical Laboratory Services 4th Floor, Southwark Wing, Guy's Hospital, Great Maze Pond, London SE1 9RT  Tel 02071881275 |  |