**Molecular Testing Request Form**

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

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| **Test Required:** |
| **Chromosome Breakage Disorder Testing** |

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| **Requirements:** |
| **5mls Lithium Heparin peripheral blood** |

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| **Clinical Details:** |  |
| NB: See website for detailed request form: <http://www.guysandstthomas.nhs.uk/services/genetics/cytogenetics/> | |

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| **Sample Type:** | **Peripheral Blood** | **Bone Marrow** |
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| **To:** | **Return to:** |
| Dept Cytogenetics, 5th Floor Tower Wing, Guy’s Hospital, Great Maze Pond, London, SE1 9RT; tel 020 7188 1702 |  |