

Genomic Medicine Service

Whole Genome Sequencing (WGS) Test Request
PLEASE DO NOT USE FOR NON-WGS TESTS

CANCER



Requesting organisation:

GLH laboratory to receive sample:

Test Required

Whole Genome Sequencing

Patient first name	Ethnicity			
Patient last name	Test Directory Clinical Indication & code (cancer type & sub-type) <i>The clinical indications listed at the bottom of the pick list under 'NEW INDICATIONS' are not live for all NHS GLHs. Please check with GLHs prior to ordering.</i>			
Date of birth (dd/mm/yyyy)		Hospital number		
Gender Male Female Other	Presentation status First diagnosis Recurrence / Relapse Unknown			
Postcode <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Additional clinical information (if required) <i>E.g. previous tumours, molecular testing, and relevant treatment history with date(s)</i>			
NHS number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Reason NHS Number not available: Patient not eligible for NHS number (e.g. foreign national) Other (provide reason):				
Solid tumour requests only				
Primary Metastatic Unknown Lymphoma	Histopathology Lab ID	Additional tumour information (if relevant) <i>E.g. site of metastasis (if metastatic), or unknown primary</i>		
	Date of this diagnosis (dd/mm/yyyy)	Tumour topography	Tumour morphology	
Haemato-oncology liquid tumour requests only				
AML ALL Other (please specify):	SIHMDS Lab ID	Date of this diagnosis (dd/mm/yyyy)		
Complete for tumour samples (being sent to GLH DNA extraction lab)				
Fresh frozen tumour	Bone marrow	Blood (EDTA)	Other (please specify):	
% malignant nuclei / blasts or equivalent in this sample (refer to sample handling guidance) must be provided below				
Sample ID	Collection date / time	% Malignant nuclei / blasts	If BM/PB provide volume and nucleated cell count	
Complete for germline samples (being sent to GLH DNA extraction lab)				
Blood (EDTA)	Saliva	Fibroblasts	Skin biopsy	Other (please specify):
Sample ID	Collection date / time	Sample volume if applicable		Comments
Responsible consultant		Main contact (if different from responsible consultant)		
Name: Department address:	Name: Department address:			
Phone: Email:	Phone: Email:			

I have attached a copy of the Record of Discussion form

Patient conversation taken place; Record of Discussion form to follow