

- USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS
- Ensure the details on this form exactly match the details on the specimen

Sample type and collection date and time to be entered here

Two items of unequivocal identification **MUST** be present. Two of the following:

- Full name
- Date of birth
- MRN

Enter referring hospital name here

Enter genetic sex

Home address of patient may be added here

Despatch laboratory number may be entered here

Please add any additional copy holders to this box

YES must be circled for testing to proceed

It is not essential for consent question 2, 3, and 4 to be answered, however it will be assumed consent has not been given if not circled

Patient or Guardian MUST sign for sample to be processed

Consultant name and hospital department/address/contact number **MUST** be entered.

Test requested, current diagnosis and clinical information are essential to proceed with testing. This ensure the scientists has sufficient information to select the correct test

Relevant family history should be recorded here to aid testing and interpretation

Consent **MUST** be signed by Consultant, Specialist Registrar in genetics or Genetic Counsellor for testing to proceed

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 Children's Health Ireland at Crumlin, Dublin 12
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Sample Type: _____

Sample Collection: _____

First Name(s): _____ Patient's Hospital Record No. (MRN): _____

Home Address: _____ Date of Birth (DOB): _____ Sex: _____

Consultant/GP (First Name and Surname): _____ Referring Hospital Pathology/Dispatch No.: _____

Tel. Number: _____

Genetics Pedigree No. (internal use): _____ Ward/Clinic/Surgery address & contact number: _____ Send additional copies of report to: _____

Details of Test(s) Requested: _____

Current Diagnosis: _____

Clinical Information: If relevant, please circle one if the following: Affected / Unaffected / Carrier Status / Unknown

Family History: (include details of name & DOB of index case & relationship)

Informed Consent: Please circle YES or No as appropriate

Patient or Guardian: I consent to be tested for the genetic test(s) and understand the implications of the test YES / NO
 I consent for the DNA from this sample to be stored YES / NO
 I consent for this sample to be used for quality assurance and audit purposes YES / NO
 I consent for the results of this test to be available to assist in testing other family members YES / NO

Patient/Guardian Signature: _____ Date: _____
 NOTE re Diagnostic Huntington Disease (HD) referrals: an additional consent form is required, see CHI at Crumlin website
 Consent Undertaken by (Referring Consultant/Genetic Counsellor):
 Signature: _____ Date: _____ Medical Council Registration No: _____
 Please note: As the referring consultant requesting this test you are taking responsibility for any actionable findings in the final report.

DCG lab no (internal use only): _____ Page 1 of 2 Date/time of receipt (internal use only): _____

- RED** – Essential information **MUST** be present of the sample will not be processed
- ORANGE** – Useful information - sample may be processed in absence of this information but there may be a delay in the results
- GREEN** – Helpful information but not necessarily required for testing