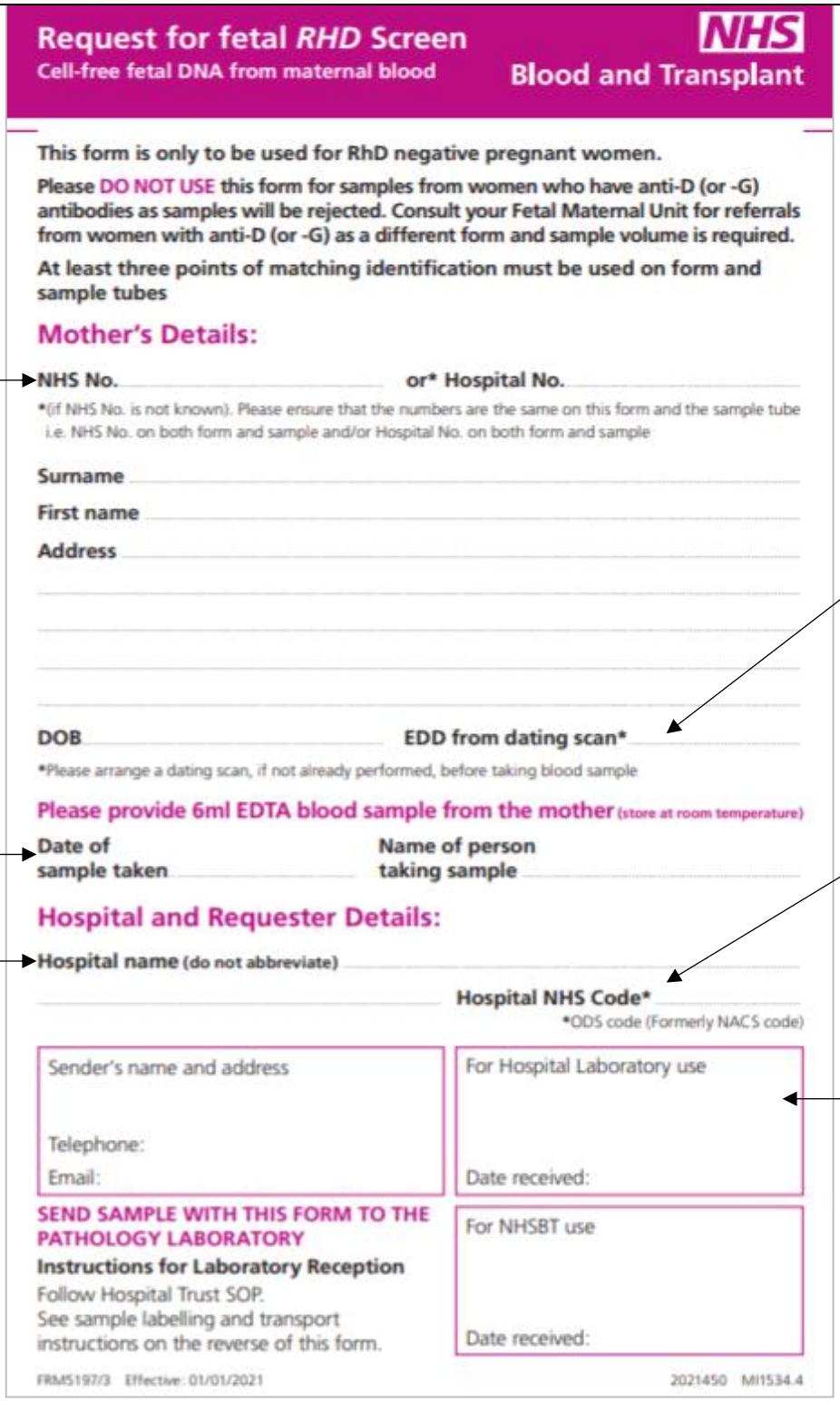
INF1340/2 – Guidance for completion of molecular diagnostics request form FRM5197

Blood and Transplant
Copy No:
Effective date: 19/01/2021

A minimum of three matching points of ID are required on both the sample and the accompanying form. See the Fetal *RHD* screening user guide (INF1259) for full sample and request form requirements



Request for fetal *RHD* Screen
Cell-free fetal DNA from maternal blood
NHS Blood and Transplant

This form is only to be used for RhD negative pregnant women.

Please DO NOT USE this form for samples from women who have anti-D (or -G) antibodies as samples will be rejected. Consult your Fetal Maternal Unit for referrals from women with anti-D (or -G) as a different form and sample volume is required.

At least three points of matching identification must be used on form and sample tubes

Mother's Details:

NHS No. _____ or* Hospital No. _____

*(if NHS No. is not known). Please ensure that the numbers are the same on this form and the sample tube i.e. NHS No. on both form and sample and/or Hospital No. on both form and sample

Surname _____

First name _____

Address _____

DOB _____ EDD from dating scan* _____

*Please arrange a dating scan, if not already performed, before taking blood sample

Please provide 6ml EDTA blood sample from the mother (store at room temperature)

Date of sample taken _____ Name of person taking sample _____

Hospital and Requester Details:

Hospital name (do not abbreviate) _____

Hospital NHS Code* _____

*ODS code (Formerly NACS code)

Sender's name and address

Telephone:

Email:

For Hospital Laboratory use

Date received:

SEND SAMPLE WITH THIS FORM TO THE PATHOLOGY LABORATORY

Instructions for Laboratory Reception

Follow Hospital Trust SOP.
See sample labelling and transport instructions on the reverse of this form.

For NHSBT use

Date received:

FRM5197/3 Effective: 01/01/2021 2021450 MI1534.4

An NHS number is preferred for fetal *RHD* screening, if it is not available a hospital number may be used.

Date on sample submitted with this form for investigation. **Must** include year, e.g. 01/02/21, not just 01/02.

The **full** hospital name **must** be included. Please do not abbrieviate. The hospital name and code determine where the report will be sent.

An estimated date of delivery (EDD) is essential for fetal *RHD* screening for identification of the pregnancy. EDD **must** be determined by **scan** before taking a sample. Number of weeks' gestation is not sufficient.

Use the 5 digit code. It is variously known as NHSIA/NACs or ODS code. (It is not the 4 character hospital code).

Place your hospital specimen barcode in this box if you need the number on the report. The same number must be on the sample tube to be included on the report. Please ensure the barcode does not obscure any patient information on the sample.