

INF1342/2.1 – Guidance for Completion of Molecular Diagnostics Request Form FRM4739



Blood and Transplant
Copy No:
Effective date: 01/06/2022

As a minimum, **three points of matching identification** (full name, DOB and unique identifier -hospital number / NHS number) **must** be included on both the samples and the accompanying form. The samples **must** be **signed** and **dated** by the person taking the blood. Please see User Guide ([INF1135](#)) for full details.

Please note the request form is electronically editable

FRM4739/3.3 – Request for fetal sex typing from maternal blood



Blood and Transplant
Effective date: DRAFT

Please use block capitals and complete all sections. Please see [page 2](#) for sample and transport requirements

Essential details are highlighted with an * - please ensure these "essential detail" sections have been completed

Patient Details <small>(essential details *)</small>		Fetal sex typing from maternal blood	
Surname *		16ml EDTA blood	
First name *		Do not send DNA prepared from plasma	
Date of birth *		Ship at ambient temperature, to arrive within 7 days	
Hospital number *		Diagnosis and Clinical History	
NHS number <small>(* UK customers only)</small>			
Hospital sample ID *			
Sample date *			
Gestation / EDD *			
Multiple pregnancy *	Yes / No		
Known risk of infection?	Yes / No		

Include diagnosis and clinical history if available

Please include requester address including department, postcode, telephone number and email address

Requester Details <small>(destination for report)</small>		Name of Sender	
Name			
Department		Sender telephone number / email <small>(For NHSBT contact purposes only)</small>	
Address		Send invoice to: (This must be provided by non-UK customers)	
Postcode			
Tel			
Fax			
Email <small>(For NHSBT contact purposes only)</small>			

Please include the sender details here if different to the requester.

This is where the report will be sent.

Terms and Conditions
Our investigations require testing of an individual's DNA, and storage for possible testing or quality assurance purposes in the future. All genetic testing requires informed consent, and it is the responsibility of the requester to ensure this is obtained. NHSBT will assume that consent has been obtained prior to referral to our laboratories. By signing and submitting this Referral Form to NHSBT the Purchaser is acknowledging that the NHSBT Terms and Conditions apply to this Referral. Where the contracting party has a Service Level Agreement with NHSBT which includes the provision of IBGRL services then the Service Level Agreement shall take precedence, and all provisions of that Agreement and subsequent amendments will apply in full. <small>1) NHS Blood and Transplant a Special Health Authority established under SI 2005 No 2529 of 500 North Bristol Park, Filton (NHSBT) and 2) Company Name (as above) (The Purchaser)</small>

Samples referred from outside the UK can be sent as frozen plasma aliquots. Refer to the User Guide [INF1135](#) for full details

International Users: Please include international dialling code with telephone number.

Requester Signature:	Date:
-----------------------------	--------------

Non-NHS England requesters **MUST** sign and date the referral form to show acknowledgement of NHSBT Terms and Conditions

NHSBT USE ONLY	
Hematos Barcode	Number of samples received:
	Date received:
	Sample ID: