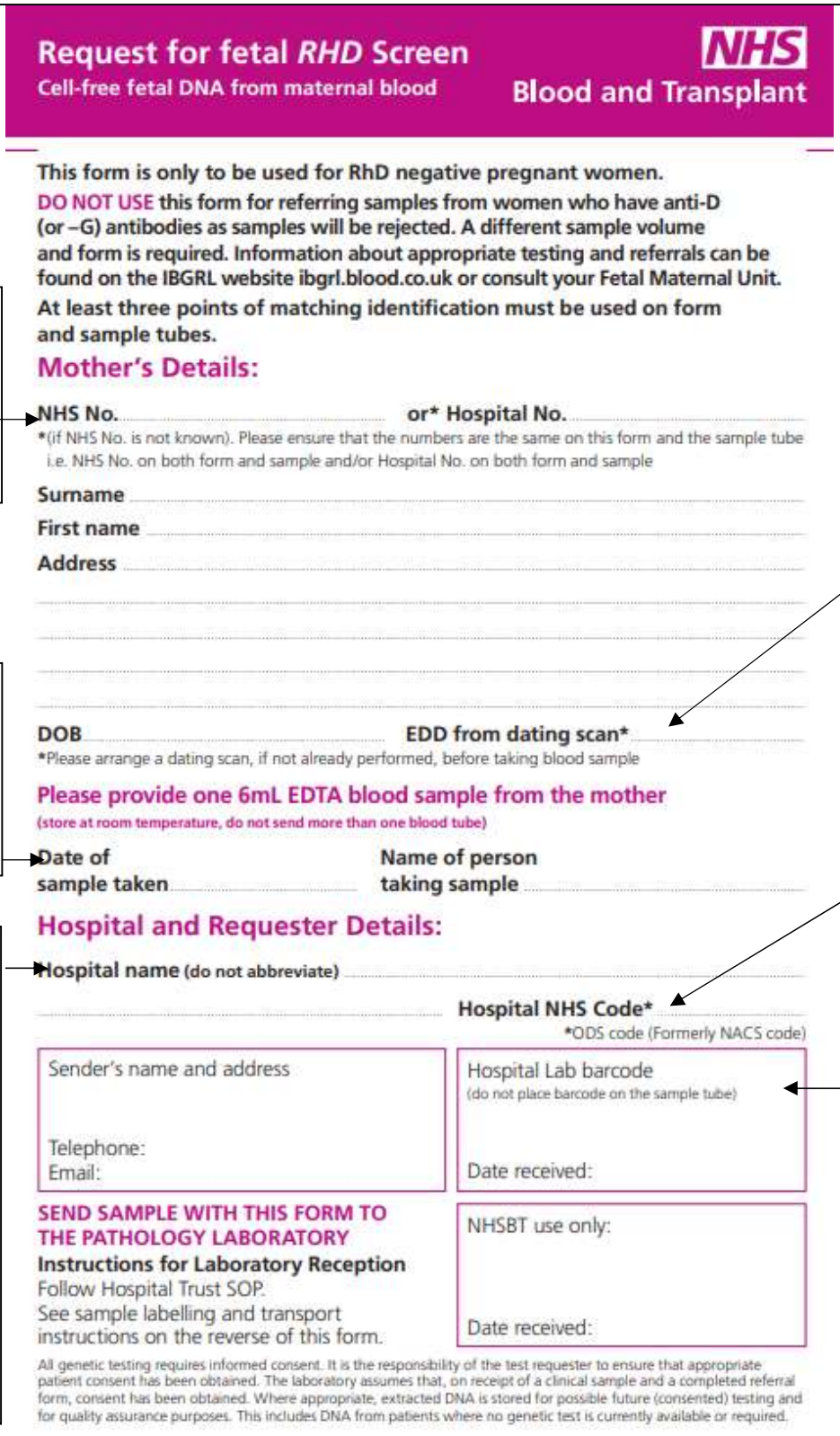
INF1340/2.3 – Guidance for completion of molecular diagnostics request form FRM5197

NHS Blood and Transplant
Copy No:
Effective date: 02/10/2023

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.

DO NOT USE this form for referring samples from women who have anti-D (or –G) antibodies as samples will be rejected. A different sample volume and form is required. Information about appropriate testing and referrals can be found on the IBGRL website ibgrl.blood.co.uk or consult your Fetal Maternal Unit.

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 one 6mL EDTA blood sample from the mother

(store at room temperature, do not send more than one blood tube)

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:

Hospital Lab barcode
(do not place barcode on the sample tube)

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.

NHSBT use only:

Date received:

All genetic testing requires informed consent. It is the responsibility of the test requester to ensure that appropriate patient consent has been obtained. The laboratory assumes that, on receipt of a clinical sample and a completed referral form, consent has been obtained. Where appropriate, extracted DNA is stored for possible future (consented) testing and for quality assurance purposes. This includes DNA from patients where no genetic test is currently available or required.

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

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.

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

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

The **full** hospital name **must** be included. Please do not abbreviate. **The hospital name and code determine where the report will be sent.** If the test request is issued from a different hospital to the delivery hospital, please consider which hospital should receive the report.

Place your hospital specimen barcode in this box if you need the number on the report. Do not place on the sample tube.