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) ***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.***
Date of birth *(dd/mm/yyyy)* / Hospital number	
Gender ☐ Male ☐ Female ☐ Other	Presentation status ☐ First diagnosis ☐ Recurrence / Relapse ☐ Unknown
Postcode	Additional clinical information (if required) *E.g. previous tumours, molecular testing, and relevant treatment history with date(s)*
NHS number 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) *E.g. site of metastasis (if metastatic), or unknown primary*	
	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: Phone: Email:	Name: Department address: Phone: Email:

☐ **I have attached a copy of the Record of Discussion form**

☐ Patient conversation taken place; Record of Discussion form to follow