B & T CELL CLONALITY ANALYSIS REQUEST FORM

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FOR LABORATORY USE ONLY			
SCMD No:	**Received by:**	**Prepared by:**	**Received:** (Date/Time)

INDIVIDUAL AUTHORISING REQUEST (e.g. Clinician / Pathologist)	
Name:	**Address:**
Phone:	

DESTINATION FOR ANALYSIS REPORT (ESSENTIAL – Results may be delayed if not completed)	
Name:	**Address:**
Phone:	**Note: If as above please tick here** ☐

Required Method(s) for Report Delivery *(please tick all that apply)*: **Post** ☐ **Fax** ☐ **Email** ☐

Results Fax number(s):	**Results e-mail(s):**

INVOICING DETAILS (ESSENTIAL – Results may be delayed if not completed in full)	
Contact name:	**Full Organisation Name and Postal Address/Post code:**
Phone:	
Email:	**Note: An authorisation code is mandatory if providing private medical insurance details**

PATIENT DETAILS (At least 3 unique identifiers are mandatory)			
Surname:	**Forename:**	**DOB** *(DD/MM/YY)*:	**Gender:** **M** ☐ **F** ☐

Hospital Name:	**Surgical Case ID:**	**Hospital Number:**	**Requester Ref (if applicable):**

SAMPLE / PATHOLOGY DETAILS (A copy of the histology report is required in all cases)

Material Supplied: *(see website for tissue requirements)*

☐	**FFPE Block**	☐	**Unstained Slides**	☐	**Sections 'curls'**	☐	**Other:**_____

Diagnosis:	**Biopsy Site:**

ADDRESS FOR RETURN OF UNUSED MATERIAL

Note: If left blank, material will be returned to the same address as specified for the analysis report.

ANALYSIS REQUIRED

☐ **B-Cell Clonality**	☐ **T-Cell Clonality**	☐ **B& T-Cell Clonality**