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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| By completing this request form, you confirm the following:   1. you have complied with the requirements as set out in this form, the Anthony Nolan Testing Services terms and conditions and where appropriate, Anthony Nolan’s Histocompatibility Laboratories Service Provision User Guide; 2. you have obtained the appropriate patient or donor informed consent as applicable, and all other permissions required in accordance with all applicable law and regulation and guidelines or otherwise in order to permit the conduct of testing you have requested on the samples; and   subject to acceptance by Anthony Nolan, you agree to be bound by the Anthony Nolan Testing Services terms and conditions available to view on our website at <https://www.anthonynolan.org/clinicians-and-researchers/transplant-and-laboratory-services/transplantation-services/guides-and-forms>, to the exclusion of all other terms and conditions (including any which you purport to apply subsequent to submission of this form). | | | | | | | | | | | | | |
| **PATIENT/ DETAILS** | | | | | | | | | | | | | |
| First Name |  | | | | | Middle Name | |  | | Surname | |  |
|  | |  | | | | | |  | NHS Number | | |  | |
| Date of Birth | |  | | | Hospital Number | | |  | NHS Number | | |  | |
|  | |  | | |  | | |  |  | | |  | |
| Sex at Birth | |  | | | Ethnicity | | |  |
|  | |  | | |
| Requesting Hospital/  Department | |  | | | Requesting Doctor | | |  | Contact details for whom the results are to be sent | | |  | |
|  | | |  |  | | |  | |
| NHS / Private Patient (Please tick) | | | NHS | Private | | | **URGENT** | | | |
| **OLLECTION DETAILS** | | | | | | | | | | | | | |
| Date | |  | | | Time | | |  | By | | |  | |

|  |  |
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| **CLINICAL INDICATION FOR TEST** |  |

Iron Overload  Family Screening

OTHER DIAGNOSIS: (Please give details)

|  |
| --- |
| **1.**The blood tube must have the patient’s name, hospital no. and DOB clearly identifiable.  **2.** Enclose a copy of this form fully completed.  **3.** Please forward **4mL blood collected in EDTA** (purple top tube) to the address above marked ‘Haemochromatosis Testing’, for the attention of the Clinical Support Team. We can receive blood Mondays-Fridays 8am-5pm excluding bank holidays.  **4.**For RFH, samples can be deposited at the **Lyndhurst Rooms (1st Floor) and Pathology laboratories**.Samples should be placed in the box labelled ‘Anthony Nolan’ for collection. Samples are routinely collected at the end of the day.  **5.** If you need to contact us please email **clinicalservices@anthonynolan.org** |

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| **THIS SECTION MUST BE COMPLETED IN FULL** | | Name of Invoicee | |  | | **Purchase Order Number** |  |
|  | | |  | |  |  |  |
| Address of Invoicee |  | | | | | | |

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| --- | --- | --- | --- | --- |
| **FOR LAB USE ONLY** |  |  |  |  |
| Patient / Donor Number |  | Sample number |  |
|  |  |  |  |
| Date / Time Received |  | Received By |  |