

PHARMACOGENETICS TEST REQUEST FORM

PATIENT DETAILS

Complete ONLY if no label available

Affix patient label here	Hospital/Clinic No. <input style="width: 100%;" type="text"/> Sample ID <input style="width: 100%;" type="text"/> Patient Initials <input style="width: 100%;" type="text"/> Date of Birth <input style="width: 100%;" type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F	Lab21 Sticker ONLY
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SAMPLE DETAILS

Sample collection date

(e.g. JAN)

TESTS REQUESTED (tick as appropriate)

HLA-B*5701
 UGT1A1¹
 CYP2B6²

CLINICAL CENTRE INFORMATION

Customer number <input style="width: 100%;" type="text"/>	Tel <input style="width: 100%;" type="text"/>
Address <input style="width: 100%;" type="text"/>	Fax <input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	Email <input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	Contact <input style="width: 100%;" type="text"/>
Postcode <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	

REQUESTING HEALTH PROFESSIONAL

Name (BLOCK CAPITALS)

Date

(e.g. JAN)

COMMENTS

In requesting the test, the health professional confirms that informed consent was obtained for testing and possible storage, and results and information obtained from it may be shared with the patient's family and health professionals responsible for their care.

FOR LAB21 USE ONLY

Date of sample receipt Lab21 ID

¹*28 polymorphism ²Position 516 G>T polymorphism

Please return the completed form, together with a blood specimen of at least 1ml in volume in a plastic EDTA tube to:

Lab21 Ltd, 184 Cambridge Science Park, Cambridge, CB4 0GA, UK

DX address: Lab21, DX 6055300, Cambridge 94 CB

T 01223 395 450 F 01223 395 451 E info@lab21.com