DEPARTMENT OF CLINICAL GENETICS
SECTION GENOME DIAGNOSICS (GD)

# REQUISITION FORM RNA ANALYSIS

The section GD is NEN-EN-ISO 15189:2012 accredited by the Dutch Accreditation Council. The scope for accreditation number M007 can be found at www.rva.nl.

TESTING RvA M 007

Surname and initials*
Name spouse
Street name and number*
Postal code and city*
Country*
Date of birth (yyyy/mm/dd)*
Sex*

* REQUIRED FIELDS

**Patient information/ Fill out completely**


**Postal adress**
LUMC, Building 2
KG, Genome diagnostic S-06-P
Visiting address: Einthovenweg 20,
Reply number 10392
2300 RC Leiden
The Netherlands

**Administration:**
Tel: +3171-5269800
Email: genoomdiagnostiek@lumc.nl
Website: www.LUMC.nl/klingen


**PROCEDURE:** Always consult us prior to sending material for RNA isolation at genoomdiagnostiek@lumc.nl .
Contact person Genome diagnostics date (yyyy/mm/dd)
Announce material at least 3 days before sending. All materials must be clearly labelled with the patient number, name and date of birth.

**MATERIAL:** Lithium **HEPARINE** 1 tube (5 ml). PN: PAXgene Blood RNA tubes **only after agreement** with the laboratory.
5 à 10 mg snap-frozen Muscle biopsy (detailed instructions available upon request)
Other materials: please contact us for instructions

**TRANSPORT:** Lithium heparine blood: At room temperature to the address above.
Blood should arrive within 36 hours after blood collection, at weekdays and before 4:00 p.m. of the second day.
Samples from collections on Friday should arrive that same day before 4:00 p.m. Snap-frozen muscle biopsies with sufficient dry ice (at least 5 kg) should preferably be sent on Monday or Tuesday.
For other materials: please contact us for instructions.

**FORM:** Please fully complete the form (one form per person).
**PATIENT INFORMATION:** Please give to the patient, this can be found at www.LUMC.nl/klingen
*For diagnostic turnaround times, our current criteria for diagnostic requests and opening hours, see our website.*
**Objection to other use of remaining material: yes ☐ no ☐**

**REFERRING PHYSICIAN**
Hospital/Institution
Address
Postal code / City
Telephone
Department
Your ref. no.
E-mail address

**REASON FOR REFERRAL**
- ☐ confirmation/exclusion of clinical diagnosis
- ☐ presymptomatic testing
- ☐ carrier detection (for recessive diseases only)
- ☐ testing for family members
- ☐ testing effect of a previously identified VUS (variant of unknown significance) **our ref**:
- ☐ other:

**GENE(S) / TEST**

**DATE OF BLOOD COLLECTION(yyyy/mm/dd)**

**TIME**

Did you previously send us material from the patient or a family member?
Known mutation/variant: yes:

☐ **NO**
☐ **YES** (this patient)
☐ **YES** (family members, fill in table)
Family number (F-nr):

**ADDITIONAL CLINICAL INFORMATION and/or PEDIGREE** (mark the person to be investigated with an arrow):

Information of tested family members:

| Name (full) | Date of birth (yyyy/mm/dd) | Sex | Relation to current patient |
|---|---|---|---|
| | | | |

**TO BE FILLED OUT BY PATIENT SECRETARY:**

Datum ontvangst:
Tijdstip ontvangst:
Materiaal en aantal: bloed/anders

Paraaf ontvangst:
Familienummer: