DEPARTMENT OF CLINICAL GENETICS
LABORATORY FOR DIAGNOSTIC GENOME ANALYSIS - LDGA

REQUISITION FORM RNA ANALYSIS

The LDGA 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

Mailadress:
LDGA
LUMC - building 2, Postal zone S-06-P
Einthovenweg 20, 2333 ZC Leiden
P.O. box 9600, 2300 RC Leiden
The Netherlands

Administration:
Tel. : +31 71 5269800
Fax : +31 71 5268276
Email : ldga@lumc.nl
Website : www.lumc.nl/klingen /

PROCEDURE: Always consult us prior to sending material for RNA isolation at LDGA@lumc.nl .
Contact person LDGA 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: **RNA TESTING:** Lithium **HEPARINE** 1 tube (5 ml). PN: PAXgene Blood RNA tubes **only after agreement** with the laboratory.

TRANSPORT: 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.

FORM: Please fully complete the form (**one form per person**).

PATIENT INFORMATION: Please give to the patient, this can be found at https://www.lumc.nl/org/klinische-genetica/patientenzorg/aanvragen-laboratoriumdiagnostiek/?setlanguage=English&setcountry=en

For diagnostic turnaround times, our current criteria for diagnostic requests and opening hours, see our website.

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?

- ☐ **NO**
- ☐ **YES** (this patient)
- ☐ **YES** (family members, fill in table)

Family number (F-nr):

Known mutation/variant: yes:

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: