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

Please fully complete the form (one form per person).

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 diagnostics S-06-P

Visiting address/ Courier service:
Einthovenweg 20, 2333 ZC Leiden

Reply number 10392, 2300 WB 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.
-5-10 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.

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.
When requesting this genetic test, we assume that the risk of incidental findings was discussed with the patient.

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):**
*required fields

***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: