REQUEST FORM: HEMATO-ONCO-GENETICS

SAMPLE INFORMATION		LNS BARCODE LABEL
Your sample identification Your ID Label	**Sample type / quantity:** ☐ Heparin: ..... ☐ EDTA: ..... ☐ Bone marrow: ..... ☐ Peripheral Blood: ..... ☐ Other: ..... **Date-Time of sampling:** ...../...../..... ..... H	LNS label

LNS LUXEMBOURG

LABORATOIRE NATIONAL DE SANTE
NATIONAL CENTER OF GENETICS
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Forms available at www.lns.lu

PHYSICIAN REQUESTING THE TEST

Surname and first name of the doctor requesting the test

Address and country

Telephone / direct line

Fax

Date of request

Signature / Stamp

PATIENT INFORMATION

Birth name

First name

Married name

Sex

Date of birth

National identification number

Address and country

Patient covered by the CNS ☐ Yes ☐ No

*If not covered by the CNS, the patient will receive an invoice from the laboratory, which they may pass on to their insurance company, where applicable.

Copies to [Please note that results are returned only to the prescriber of the test, who is the only one authorized to give them to patients.]

PREANALYTICAL CONDITIONS

Karyogram and FISH	At least 10 mL heparinised blood or 5mL heparinised bone marrow ➔	 (green tube: Heparin)
Molecular genetics	10ml peripheral blood (EDTA) or 5mL bone marrow EDTA ➔ For **qRT-PCR BCR/ABL** t(9;22) (p210) (quantitative) **PAXGENE** or EDTA	 (purple tube: EDTA)
***Specific sample:**	For MPN, MDS, NHL and MM ➔ Bone marrow sample is mandatory	

CLINICAL INFORMATION *(essential for the interpretation of results)*

Diagnosis

☐ CML ☐ MPN* ☐ MDS* ☐ AML ☐ B-CLL ☐ MM/Plasmocytoma*

☐ B-NHL* ☐ T-NHL* ☐ B-ALL ☐ T-ALL ☐ .....

**Bone marrow sample mandatory*

☐ Suspicion ☐ Initial diagnosis ☐ Remission ☐ Control ☐ Recurrence ☐ Under treatment

☐ After bone marrow transplant : ☐ allograft Sex ☐F ☐ M ☐ Autograft

☐ After-chemotherapy ☐ .....

In case of a follow up / control, please send us initial reports, if they were not performed at the LNS.

TESTS REQUESTED

Conventional cytogenetics and molecular cytogenetics (heparin sample)

☐ KARYOGRAM (microscopic banding analysis) ☐ FISH ☐ Decision based on indication

Molecular genetics (EDTA sample)

☐ B-Cell Clonality ☐ BCR/ABL t(9;22) (p210) (quantitative) ☐ Molecular test, decision based on indication / diagnosis*

☐ T-Cell Clonality ☐ JAK2 (V617F) ☐ Other molecular test(s)*,#: .....

**Performed in collaboration with an external accredited laboratory* *#Please indicate which genes should be analyzed*

OTHER CLINICAL COMMENTS / SINGLE REQUESTS:

Page 2: Consent-Form ➔

FORM-ONCO-PREANALYTICAL-RequestFormOnco [English] version 1.0

CONSENT FORM

By signing below, I consent to the genetic testing as indicated on the test request form in order to determine the genetic cause of the abovementioned clinical condition.
I hereby confirm, that the requesting physician (signed below) has informed me in detail about the medical necessity, potential benefits and limitations of the planned genetic testing. In addition, possible consequences from the communication of the test result (e.g. psychological burden) were discussed.

With your consent, **unused sample material** will be stored. Please decide if and how unused sample material may be used. I consent to the use of this material - for verifying the obtained results, laboratory quality assurance and future diagnostic investigations. - for the purposes of academic teaching and scientific research.	 ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
I consent being informed[1] of **secondary/additional findings[2]** if these have direct medical implications (e.g. possible prophylactic measures or therapeutic consequences) or may constitute a significant genetic risk for me or my family members. [1] According to current scientific understanding and based on the present recommendations of the American College of Medical Genetics and Genomics (ACMG). [2] Variants that may be obtained incidentally during the course of genetic testing and are associated with a condition other than the one for which testing was originally indicated.	☐ **Yes** ☐ **No**
If necessary, I consent that my sample material, my personal data and the test request is **forwarded** to a specialized cooperating laboratory or institute in order to investigate the above-stated condition in question.	☐ **Yes** ☐ **No**
I consent that data and test results collected in the context of the condition in question may be used in de-identified (pseudonymized) form for **scientific research**[1] and published in anonymized form in medical journals. [1] e.g. to improve the understanding of the molecular pathogenesis and develop new diagnostic or treatment possibilities)	☐ **Yes** ☐ **No**
I consent that my personal data and test results will be stored **longer than the statutory retention period of 10 years**.	☐ **Yes** ☐ **No**

I am aware that my consent applies to me and/or to my minor child(ren) and I may withdraw this consent at any time, verbally or in writing, without giving reasons.

Place and date:_____

Signature of requesting physician _____

Signature of patient or legal representative(s) _____