|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | REQUEST FOR SIHMDS-HAEM PATHOLOGY SERVICE  **Immunophenotyping** | | | | | | | |
| Request must be previously arranged with laboratory staff | | | | | | | | | | |
|  | | | | | | | | | | |
| PATIENT DETAILS | | | | | | | | | | |
| **Surname** | |  | | | | **Hospital number** **NHS No.** | | | |  |
| **Forename** | |  | | | |
| **Date of birth** | |  | | | | **Contact number** | | | |  |
| **Sex** | | M F | | | |
| **Requesting Consultant** | |  | | | |
|  | | | | | | | | | | |
| **Pre-CAR T Assessment** | | | | | |  | | Send by courier to: | | |
| **Required:**  **CD19 quantification Yes No** | | | | | | Rebecca Thomas  Flow Cytometry  Level 2  SIHMDS -Haematology Department  Camelia Botnar Laboratories  Great Ormond Street Hospital  Great Ormond Street  London  WC1N 3JH  0207 405 9200 ext. 1481/7901 | | |
| **CD22 quantification Yes No**  **CD52 quantification Yes No**  **CD7 quantification Yes No**  **Other:** | | | | |  |
|  |
| Date of sample | |  | | | |
| Specimen Type: Bone Marrow Blood (please circle) | | | | | |
| Please quote your reference number | | | | | |
|  |  | | |  | |
|  | | | | | | | | | | |
| Clinical details- include current treatment and level of measurable residual disease | | | | | | |  | | *Note incorrect information will lead to incorrect interpretation of analysis* | |
|  | | | | | | | | | | |

|  |
| --- |
| NHS.net email address for return of analysis report: |

|  |
| --- |
| **Note:** Details of Leukaemia Associated Immunophenotype (LAIP) will need to be provided to GOSH SIHMDS Lab if we do NOT hold diagnostic or relapse analysis on this patient. Sample may not be processed if information not received.  **Please confirm that this has been emailed -** Report sent: Yes No  Dot plots sent: Yes No |