|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | 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** | |  | | | |
| nN | | | | | | | | | | |
| **Post CAR T monitoring** | | | | | |  | | Send by courier to: | | |
| **Required:**  **LAIP quantification post CAR-T Yes No** | | | | | | Rebecca Thomas  Flow Cytometry  SIHMDS -Haematology Department  **Level 2 Camelia Botnar Laboratories**  Great Ormond Street Hospital  Great Ormond Street  London  WC1N 3JH  0207 405 9200 ext 1481/7901 | | |
| **Other (write required analysis):** | | | | |  |
|  |
| Date of sample | |  | | | |
| Specimen Type: Bone Marrow Blood (please circle) | | | | | |
| Please quote your reference number | | | | | |
|  |  | | |  | |
|  | | | | | | | | | | |
| Clinical details- include Timepoint and treatment details | | | | | | |  | | Note incorrect information will lead to incorrect interpretation of analysis | |
|  | | | | | | | | | | |

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

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| **Was Pre-CAR-T assessment by flow cytometry performed at GOSH YES** **NO** (complete below)  **If** details of Leukaemia Associated Immunophenotype (LAIP) are not held at GOSH then details of LAIP will need to be provided. 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** |