Leeds Cancer Centre

The Leeds Teaching Hospitals NHS
NHS Trust

HAEMATOLOGICAL MALIGNANCY DIAGNOSTIC SERVICE

Level 3 Bexley Wing, St. James's University Hospital, Beckett St. Leeds LS9 7TF
Tel: 0113 2067851 Email: hmds.lth@nhs.net

Use Addressograph if Available (ON REQUEST FORM ONLY)

Please complete ALL sections:

Surname:	**Forename:**
NHS number:	**Patient number:**
Date of birth:	**Male / Female**
Referring hospital:	**Consultant:**
Is this a Danger of Infection (DoI) sample?	**Yes / No**
If yes, is there any microbiological/radiological evidence of TB?	**Yes / No**
Previously investigated by HMDS	**Yes / No**

At least 3 points of Identification are required

Please label forms and sample(s) adequately

PLEASE TELEPHONE DEPARTMENT IF URGENT RESULT REQUIRED

Specimen type(s):	**Sample ref number:** Number of Blocks..... / Number of slides.....	**Hb:**	**WBC:**
Suspected diagnosis:		**Neut:**	**Lymphs:**
Who should this report be returned to:		**Plts:**	**Other:**
Recent chemo/radiotherapy details:			
Clinical details (REQUIRED IN ALL CASES):			
Specimen taken by (FULL NAME REQUIRED IN ALL CASES):	**Contact details:**		
Date / Time of sample:			

For Laboratory Use Only		
Date & Time:	**Initials:**	**HMDS Error Code**
Contents:		

Gross Description: ..... core of tissue.....mm in length Dabs/flow/paraffin/frozen	**H.E** Blocking out..... Microtomy..... Staining..... Q.C..... **REQUESTS** Microtomy..... Staining..... Q.C.....