

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 Website: www.hmds.info

PLEASE TELEPHONE THE DEPARTMENT IF AN URGENT RESULT IS REQUIRED

Please complete ALL sections legibly

Use Addressograph if Available (ON REQUEST FORM ONLY)

Surname:	Forename:
NHS number:	Patient number:
Date of birth:	Male / Female
Referring Hospital (FULL NAME REQUIRED):	Consultant (FULL NAME REQUIRED):
Is this a Danger of Infection (DOI) sample? Yes / No If Yes, please specify DOI risk within the clinical details & affix DOI labels to request form and all sample(s)	
If yes, is there any microbiological/radiological evidence of TB? Yes / No	
Please affix/state your local laboratory No./ID to appear on the HMDS report:	

A minimum of 3 patient identification points are required for the processing of this request

Please label forms and sample(s) adequately

Specimen Type(s):	If applicable: Number of Blocks..... Number of Slides.....	Hb:	WBC:
Suspected Diagnosis:		Neut:	Lymphs:
Recent chemo/radiotherapy Details:		Plts:	Other:
Clinical Details (REQUIRED IN ALL CASES):			
Date & Time of Sample Taken:			
Specimen Taken by (FULL NAME REQUIRED):		Contact details (telephone No.):	
Who should this report be returned to (email: nhs.net):			

For Laboratory Use Only		
Date & Time:	Initials:	HMDS Error Code
Contents:		
Gross Description: core of tissue.....mm in length		