NHS
The Leeds Teaching Hospitals
NHS Trust

HMDS, Level 3 Bexley Wing, St. James's University Hospital, Beckett St. Leeds LS9 7TF

Tel: 0113 2067851

Use Addressograph If Available (ON REQUEST FORM ONLY)

Please Complete ALL Sections:

Surname:	Forename(s):	GP name:
NHS number:	Patient number:	GP surgery:
Date of birth:	Male / Female:	
Referring hospital:	Consultant:	

Please provide the most recent applicable results

FBC date of test:		Immunology date of test:					
Hb:	g/L	IgG		g/L			
WBC:	10^9/L	IgA		g/L			
PLT:	10^9/L	IgM		g/L			
Lymphs:	10^9/L	Paraprotein concentration				g/L	
		PP Isotype	IgG	IgA	IgM	Kappa	Lambda
Biochemistry date of test:		Free Kappa LC		mg/L			
Creatinine	µmol/L	Free Lambda LC		mg/L			
Calcium	mmol/L	sFLC ratio					

Please scan the completed request form and email to: leedsth-tr.HMDSOutreach@nhs.net

Clinical details (REQUIRED IN ALL CASES):

- ☐ MGUS
- ☐ MBL or ☐ CLL (please tick according to the diagnosis that the patient has been provided)
- ☐ CLL monitoring after treatment: please state Rx end date __________and Rx type ___________________
- ☐ CML: please state current treatment ________________________________
- ☐ Other (please state): ___________________________________

I confirm that

The clinical features are stable and/or consistent with a low risk of disease progression

The patient is aware of the relevant symptoms and capable of completing the questionnaire

Any current symptoms are unrelated to the haematological disorder

Referral request made by: Name (block capitals):

Signature: Date:

Contact details:

For Laboratory Use Only

Date & Time: Initials: HMDS Error Code

Comments: