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 **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? **If Yes, please specify DOI risk within the clinical details & affix DOI labels to request form and all sample(s)**	**Yes / No**
If yes, is there any microbiological/radiological evidence of TB?	**Yes / No**
Please 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		