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: