

## Haematological Malignancy Diagnostic Service

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

Tel: 0113 2067851 Fax: 0113 2067883

**Use Addressograph if available (ON REQUEST FORM ONLY)**

Surname:	
Forename(s):	
NHS number:	Patient number:
Date of birth:	Male / Female
Source hospital:	Consultant:
Is this a Danger of Infection (DOI) Sample? Yes/No	

At least 3 points of identification are required

Please label forms and sample(s) adequately

**Please attach DOI stickers for High-Risk samples**

Sample type enclosed:	PNH Biobank 7ml	EDTA <input type="checkbox"/>	Serum <input type="checkbox"/>
Peripheral Blood (EDTA) 2-5ml <input type="checkbox"/>			
Bone Marrow Aspirate <input type="checkbox"/>			
Bone Marrow Trephine <input type="checkbox"/>	Other.....		

Type of Request:			
New PNH Patient <input type="checkbox"/>	PNH screening (no previous PNH test) <input type="checkbox"/>		
Eculizumab follow-up <input type="checkbox"/>	PNH follow-up (Not on eculizimab) <input type="checkbox"/>		
Pre Eculizumab <input type="checkbox"/>	Aplastic anaemia follow-up <input type="checkbox"/>		

Clinical Information (please tick all that apply):				
Haemolytic <input type="checkbox"/>	Aplastic anaemia <input type="checkbox"/>	Thrombosis <input type="checkbox"/>	MDS <input type="checkbox"/>	MPD <input type="checkbox"/>
Transfusion within 6 months? Yes/No. If yes, date of last TF and number of units.....				

Other Relevant Information: (eg- immunosuppressive therapy/site of thrombosis/haemoglobinuria)		
Specimen sent by:	Date & time of sample:	Contact details:

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