



## MEDICAL GENETICS

### PLASMA cfDNA *EGFR* ANALYSIS REQUEST FORM\*

\*cfDNA isolated using the cobas® cfDNA Sample Preparation Kit and analysed for mutations in the *EGFR* gene by the cobas® *EGFR* Mutation Test v.2

<b>Samples to be sent to: NHS Grampian Medical Genetics, Polwarth Building, Foresterhill, AB25 2ZD</b>			
<b>Sample Checklist:</b>			
<b>ARI ONLY:</b> A <b>minimum</b> of 2 x 8ml K2-EDTA vacutainers. Please fill to the line and invert appropriately.			
<b>EXTERNAL SITES:</b> 1 x 10ml Streck Cell-Free DNA BCT® preservative tube, please fill to the line. Invert gently 10 times; inadequate mixing can affect performance. Streck tubes should <u>not</u> be refrigerated or frozen. <b>N.B.</b> Transfer of blood collected using a syringe and needle is not recommended as it increases the potential for haemolysis which may have an impact on the quality of the results. Please see <a href="https://www.streck.com/products/stabilization/cell-free-dna-bct/">https://www.streck.com/products/stabilization/cell-free-dna-bct/</a> or see <a href="http://www.nhsgrampian.org/medicalgenetics">www.nhsgrampian.org/medicalgenetics</a> for further information.			
Patient Identifiers are on tube and referral form			
Date and time of sample are on tube and referral form			
<b>BLOOD SHOULD BE SENT TO THE LABORATORY AS SOON AS POSSIBLE AFTER COLLECTION - ELONGATED PROCESSING TIMES CAN AFFECT RESULTS.</b>			
<ul style="list-style-type: none"> <li>• K2-EDTA tubes must be received before 4pm and should be sent within an hour of sample collection.</li> <li>• Streck Cell-Free BCT® tubes should be sent within 24 hours of collection.</li> </ul>			
<b>Essential Patient Details (printed labels can be used)</b>			
Forename:		Surname:	
CHI No:	Date of Birth:	Male/Female (Please circle)	Ethnicity:
Address ( <u>must</u> include postcode):			
			Postcode
<b>Essential Clinical Information (Add information / circle as appropriate)</b>			
<b>Date blood taken:</b>		<b>Time Blood Taken:</b>	
Reason for test (please tick)			
Biopsy not possible or inadequate <input type="checkbox"/>		fill in relevant fields below	
Progression on EGFR-TKI therapy <input type="checkbox"/>		fill in relevant fields below	
Other (please state) <input type="checkbox"/>		_____ (fill in relevant fields below)	
Does the patient have a confirmed diagnosis of NSCLC? YES / NO		TNM (if known):	
Tumour histology: Adenocarcinoma / Squamous / Large Cell / NOS		Is the patient chemo-naïve? YES / NO	
Smoking Status: Never / Ex <15 years / Ex >15 years / Current		Pack Years:	
Has a tissue sample been tested previously for <i>EGFR</i> mutations? YES / NO			
If yes, <i>EGFR</i> mutation(s) detected: _____			
Is the patient on EGFR-TKI treatment? YES / NO		If yes, which drug: _____	
If showing signs of clinical progression on an EGFR-TKI, please provide further details of progression:			
<b>Referrer(s) Details</b>			
<b>N.B. Diagnostic reports will be available on Grampian SCI Store</b>			
Hospital _____		Ward / Department _____ Requesting Clinician(s) _____	
Email address(es): _____			
<b>To be completed by Medical Genetics Aberdeen</b>			
Volume of Blood:		Correct Tube: K2-EDTA / Streck (please circle)	