Lab use only
Affix/write MMUH Lab number below:

MATER MISERICORDIAE UNIVERSITY HOSPITAL

Thrombophilia screen/Lupus anticoagulant request and patient consent form

This form must accompany any request/specimen for **Thrombophilia screen/Lupus anticoagulant/ Factor V Leiden/PT gene mutation**.
Samples **will not be analysed** unless **a fully completed** form accompanies the samples.

Sample requirements: Thrombophilia screen- 6x3ml sodium citrate (green cap) and 1x EDTA (grey cap)
Lupus anticoagulant- 6x3ml sodium citrate (green cap)

Part A: Thrombophilia screen/Lupus anticoagulant request form

Please use BLOCK CAPITALS.

Patient's name: _____

MRN (if applicable):_____ Date of birth: _____

Requesting source (Ward/Clinic/Medical centre/GP surgery):_____

The requesting clinician confirms that the request fulfils criteria as detailed in Guidelines for Heritable Thrombophilia Testing:
For in house requestors https://maternet.mmuh.ie/departments-and-offices/pathology/Guideline-for-Heritable-Thromb-testing.pdf
For external requestors http://www.mater.ie/healthcare-professionals/gpreferrals/Guideline_for_heritable_thrombophilia_testing.pdf
Please tick box which corresponds to the indication for testing below:

Asymptomatic relatives with a family history of Antithrombin, Protein C or Protein S deficiency AND a family history of thrombosis	
First venous thrombosis in a patient with a family history of unprovoked or recurrent venous thrombosis in one or more first degree relatives	
Asymptomatic relative of venous thrombosis patients with a known heritable thrombophilia prior to hormonal treatment	
Other thrombosis (e.g. cerebral venous sinus, splanchnic vein thrombosis, skin necrosis secondary to vitamin K antagonists)	
Include specific clinical details relating to this request for thrombophilia screen / LA screen. If the request is as a result of pregnancy loss, give details regarding the number and timing of pregnancy loss, number of months post pregnancy loss or post-partum:	

Testing should not be carried out while patient is on anticoagulant therapy.

Requesting doctors' name: _____ Requesting doctor's signature: _____
Please use BLOCK CAPITALS.

The requesting clinician confirms that written consent has been obtained for testing for APCRV, Factor V Leiden mutation (if APCRV test abnormal), testing for the Prothrombin gene mutation and subsequent storage of DNA samples Yes ☐

Part B: Patient consent form for genetic testing for Thrombophilia mutation analysis.

Patient information leaflet is available for in house requestors: https://maternet.mmuh.ie/departments-and-offices/pathology/Patient-information-Genetic-testing-for-Thrombophilia.pdf
For external requestors:
http://www.mater.ie/healthcare-professionals/gp-referrals/Genetic testing for Thrombophilia Patient information leaflet

Patient's name: _____

MRN (if applicable):_____ Date of birth: _____

Requesting source (Ward/Clinic/Medical centre/GP surgery):_____

I ……..…….. (Print name) give consent for a blood sample to be taken and the genetic material extracted, stored and tested for Thrombophilia mutation analysis:

Please initial the boxes below to indicate your consent:

☐ The purposes for obtaining this sample and the potential implications have been explained to me and I have had an opportunity to have my questions answered.

☐ I have read and understood the information about genetic testing.

☐ It is the intention to store the sample for a maximum two year period.

☐ I hereby give consent for clinical and genetic information that may be relevant to other family members to be made available to relevant health care professionals.

☐ I agree to the results being entered into local or national confidential databases.

Signed ……..…. Date……..

Person obtaining consent:
I have explained to the above patient/parent/legal guardian the purpose of obtaining a sample for genetic studies and their implications.

Signed ……..……..... Date……..…..

Print Name ……..…… Position……..……..

A copy of the completed Patient consent form (**Part B)** should be given to the patient, the original filed in the patient record and **should not** be sent to the laboratory with the test request**.**