THE CYPRUS INSTITUTE OF NEUROLOGY & GENETICS

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Department of Cardiovascular Genetics & the Laboratory of Forensic Genetics

Referral Letter

Department Code: 26

Personal details of patient

Case type: ☐ Outpatient ☐ Inpatient

Name: _____ Surname: _____

D.O.B.: ____ / ____ / ____ I.D. No.: _____

Nationality: _____

CING No.: _____ Hospital Card No.: _____

Patient Status:

☐ GESY

☐ Government-Non GESY Hospital Card No.: _____

☐ Private-Non GESY

Address: _____

City: _____ Code: _____ Country: _____

Phone: Home: _____ Work: _____

Referring clinician's / scientist's details

Name: _____ Surname: _____

Hospital / Clinic: _____

Referring clinical status:

☐ CING

☐ Government (ΟΚΥΠΥ)

☐ Private-GESY GESY No. _____

☐ Private-Non GESY

Address: _____

City: _____ Code: _____ Country: _____

Phone: _____ Fax: _____

e-mail: _____

Reason for Referral: _____

_____

Test Required (Code No.) *(Please tick ☑ accordingly)*

Cardiovascular Genetics:

- ☐ Familial Hypercholesterolaemia (3)
- ☐ Thrombophilia (4 mutations simultaneously) (9)
- ☐ Apolipoprotein E Genotyping (4)
- ☐ Cardio Panel (in silico panel from CES) (11.1)
- ☐ Cardio Panel (in silico panel from WES) (11.2)
- ☐ Clinical Exome Sequencing (Single patient) (15)
- ☐ Clinical Exome Sequencing (Trio) (16)
- ☐ Whole Exome Sequencing (Single patient) (17)
- ☐ Whole Exome Sequencing (Trio) (18)
- ☐ Sanger Sequencing for confirmation/screening of NGS result (19)

Forensic Genetics:

- ☐ DNA Profiling of one person (5.1)
- ☐ Duo or Trio Kinship testing (5.2)
- ☐ Each additional person to be included in Duo/Trio Kinship Test (5.3)
- ☐ Kinship Test with 1 Skeletal Element (5.4)
- ☐ Kinship Test with each additional Skeletal Element (5.5)
- ☐ Other forensic genetic services (6)

Screening for mitochondrial mutations:

- ☐ Molecular Investigation of Mitochondrial Diabetes and Deafness (MIDD) (13)

Sample Details *(Please tick ☑ accordingly)*

Date and Time of Sample Collection: _____

Sample: ☐ Blood ☐ Buccal Swabs
Other (please specify): _____

☐ First Investigation ☐ Repetition

Please tick the box if diagnostic NGS tests are being requested and fill in the following fields:

☐ Current NGS referral is for diagnostic purposes only

Please state if any other diagnostic tests have been performed for this patient Y / N

If YES state which tests:

_____

_____

If NO state why patient is referred for NGS as a first-tier test:

_____

_____

Signature: _____ Date: ____ / ____ / ____

Sample Receipt (*For Laboratory Internal Use)*

Received by: _____

Signature: _____

Sample Receipt Date: ____ / ____ / _____

Amount: _____ Comments: _____