Lab Number: ….....

Patient ID Number: ……..

Control sample referral form for Fanconi anaemia

To allow anonymisation, please **DO NOT** provide any demographics for the control sample

Sample type: **Lithium Heparin** Blood (min. volume 3ml)

Date obtained: …….....

Sex: Male/Female….....

Please send a sex and aged matched (as close as possible) control blood

Sex and Age matched: Yes/No.....

Karyotype required for Fanconi anaemia patient: Yes/No.....

Label Sample tube as follows:

CONTROL
Fanconi anaemia patient name and CHI/DOB (**NOT details of control**)