# Molecular Diagnostics (Drugs) Advisory Group

# Recommendation Form

This form should be completed by the Molecular Diagnostics (Drugs) Advisory group following the consideration of a Test Proposal Form. Test Proposal Forms are completed by referring clinical users in partnership with one or more local Molecular Pathology Laboratories where applicable.

|  |  |
| --- | --- |
| 1. **ADMINISTRATIVE DETAILS** |  |
| **1.1 Test Name** |  |
| **1.2 Test Proposal Form review date** |  |
| **1.3 Requesting individual details** | **Name:**  **Address:**  **Email:** |
| * 1. **Supporting laboratory details (*if relevant*)** | **Name:**  **Address:**  **Email:** |
| **2. Molecular Diagnostics (Drugs) Advisory Group RECOMMENDATIONS** | |
| **2.1 Group decision following the consideration of a Test Proposal Form** | **TEST RECOMMENDED FOR IMPLEMENTATION**  **Test not supported by the Advisory Group**  **Reason for decision:** |
| **2.2 Location of testing**  **If in Ireland, please indicate how many sites should deliver testing** | **In Ireland**  **Outsourced**  **Number of sites:** |
| **2.3 Testing platform to be utilised** |  |
| **2.4 For inclusion in an existing testing panel**  **If yes, please define panel** | **Yes**  **No**  **Panel details:** |
| **2.4 Timeline for testing implementation** | **0- 6 months**  **6 - 12 months**  **1-3 years** |
| **3. TESTING PATHWAY** | |
| **3.1 Is the testing time point in a patients pathway known**  **If yes, please define time point**  **If time point is not known, is there a requirement for input from a clinical guideline group** | **Yes**  **No**  **Testing time point:**  **Yes, clinical guideline group input required**  **No, clinical guideline group input NOT required** |
| **4. QUALITY ASSURANCE Requirements** | |
| **4.1 Number of tests required per annum in each laboratory to ensure QA needs are met** | **Number of tests:** |
| **4.2 Specific laboratory accreditation requirements** | **INAB approved or an application for INAB accreditation is in progress**  **Other:** |
| **5. Correspondences** | |
| **5.1 To be notified of Molecular Diagnostics (Drugs) Advisory Group Recommendation(s)** | **Requesting individual**  **Supporting laboratory**  **NCCP leads group**  **Please list NCCP leads group(s):**  **Other**  **If other please list:** |
| **6. Additional Comments** | |
| **6.1 Comment** |  |

|  |  |
| --- | --- |
| **Test recommended for implementation AUTHORSIATION SECTION** | |
| **Date of Molecular Diagnostics Advisory Group meeting** | **Date:** |
| **Authorising signature** | **Name (PRINT):**  **Signature:**  **Date:** |