# 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.

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| 1. **ADMINISTRATIVE DETAILS**
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| **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** |  |

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