TEST REQUEST AND CLINICAL DETAILS FORM

HUMAN GENETICS UNIT, FACULTY OF MEDICINE, UNIVERSITY OF COLOMBO

PERSONAL HEALTH NUMBER **DATE**

HGU REFERENCE NUMBER

NAME

SEX M F ? **DATE OF BIRTH** **AGE**

ADDRESS

PHONES

EMAIL

REFEREED BY

DESIGNATION

INDICATION

CLINIC NOTES

SPECIMEN

- BLOOD
- BM
- TISSUE
- FFPE
- OTHER

TESTS

- KARYOTYPE
- MICROARRAY
- FISH
- F5
- F2
- MTHFR
- SRY
- CAL R
- JAK2
- α THAL
- β THAL
- HFE
- FXS
- TPMT
- EGFR
- EXOME
- Re Analyze

PAYMENT

- FREE
- PAID

RESEARCH

- YES
- NO

URGENT

- YES
- NO

RECEIPT NO

SCANNED DOCUMENTS

- REFERRAL
- X-RAY
- USS
- CT
- MRI
- HAEMATOLOGY
- BIO CHEMISTRY
- PATHOLOGY

COUNSELING

- PRE-TEST
- POST-TEST
- COUNSELLING

Hospital/Dept: STRICTLY CONFIDENTIAL	Consanguinity yes / no	Family No:
I		
II		
III		
IV		
V		
KEY	Source: Date: Drawn by:	Source: Date: Updated by:	Source: Date: Updated by:

CONSENT

මගේ/මගේ දරුවාගේ/ රෝගියාගේ ජාන/වර්ණදේහ පරීක්ෂා කිරීම සඳහා කැමැත්ත ප්‍රකාශ කර සිටිමි.

நான்/ என் குழந்தை/ நோயாளிக்கு மரபணு/குரோமோசோம் சோதனைக்காக ஒப்புக்கொள்கிறேன்.

I give consent for genetic testing for Myself/My child/the Patient.

රෝගීන් / දෙමාපියන් / භාරකරුගේ නම நோயாளி / பெற்றோர் / கார்டியன் என்ற பெயர் Name of Patient/Parent/Guardian	අත්සන/கையொப்பம்/Signature	දිනය/தேதி/Date

I confirm that I have previded pre-test counseling.

Name of Doctor	Signature	Date