

CYTOGENETIC ANALYSIS USING PERIPHERAL BLOOD

Lab No	(For Cytogenetic Lab Use Only)

PATIENT'S DETAILS:

Name:	Sex:
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RN:	Age:	Hosp:
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IC no:	Birth date: / /	Ward:
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FAMILY HISTORY

Name of father:	Age:
Name of mother:	Age:







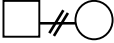
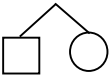


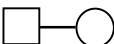
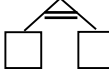


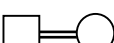
Consanguineous marriage: <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship (if yes):

No of siblings:	Death / Abortion:
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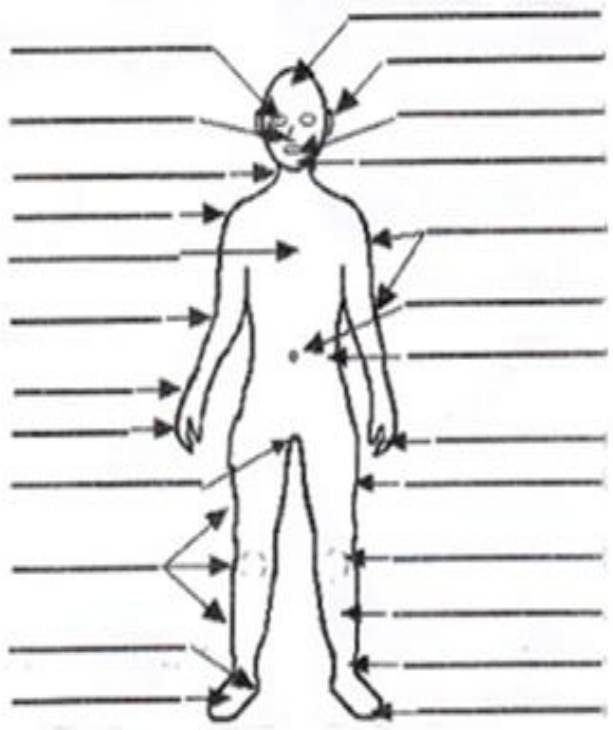
Family history of known chromosomal / genetic disorder (including blindness, mental retardation, muscular dystrophy, etc):

Pedigree (Please include at least 3 generations):

General symbols for pedigree diagram:

 / 	Normal Male / Female		Abortion		Sex unknown
 / 	Affected Male / Female		Divorced		Non identical twins
 / 	Deceased Male / Female		Marriage		Identical twins
 / 	Proband Male / Female		Consanguineous marriage		

RISK FACTORS

<p>(e.g: Maternal infection during first trimester, medication, irradiation, drug addiction, alcohol, herbal medication, supplements, etc)</p> <p>Patient:</p> <p>Parents:</p>	<p style="text-align: center;">Dysmorphic Features:</p> 
<p>Relevant clinical investigations: Blood test, radiological / imaging test, etc)</p>	
<p>Provisional diagnosis:</p>	

TEST REQUESTED (Sample collection tube) Note: For further details and appointment, please contact 09-7676789 /6804

<p>Please use Sodium Heparin tube:</p> <p><input type="checkbox"/> Conventional Karyotyping</p> <p><input type="checkbox"/> Fluorescence <i>In Situ</i> Hybridization (FISH)</p> <p><input type="checkbox"/> Chromosome Breakage Test (Fanconi Anaemia)</p>	<p>Sample collection:</p> <p>Date:</p> <p>Time:</p>	<p style="background-color: black; color: white; text-align: center; font-weight: bold;">FOR CYTOGENETIC LAB USE ONLY</p> <p>Sample received</p> <p>Date:</p> <p>Time:</p> <p>Received by:</p>
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<p>Name, signature and stamp of medical officer:</p> <p>Contact number:</p>	<p>Name of specialist / consultant:</p>
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