

PUSAT GENOM MANUSIA HOSPITAL UNIVERSITI SAINS MALAYSIA

MOLECULAR DIAGNOSTIC TEST REQUEST FORM: GILBERT'S SYNDROME

					Lab. No:		
PATIENT'S PARTIC	ULARS						
Name:		RN:		IC no:			
Sex:	Age:	Date of birth	າ:	Hosp/ Ward:			
Address:							
Name of father:			IC no:			Age:	
Name of mother:		IC no:			Age:		
Family history of cl Yes [] (If yes, p		netic disorde	ers:	No)[]		
Consanguinity: Yes	ship:	hip:			No []		
Type of sample:		Date and	time of samp	ling:			
General symbols for r		T 3 GENERA	TIONS):				
Affected Deceased	oedigree diagram: Male / Female Male / Female d Male / Female Male / Female	D N	bortion ivorced Iarriage onsanguineous narriage		Non id	nknown dentical twins cical twins	

Clinical history			Clinical features / signs				
- Common model y							
<u>:</u>							
Haamaalahin laval		الم/ما					
Haemoglobin level		g/dL					
Full Blood Picture (FBP) H		Haemolytic /	aemolytic / Non-haemolytic				
ruii bioou ricture (rbr)		Tracmorytic 7	14011	nacmorytic			
Liver function test							
Clinical diagnosis:		Name and	Name and stamp of specialist/consultant:				
		Contact no	Contact no:				
		Email:	For all.				
		Emaii:	Emaii.				
	DDO	CECCINIC I AD /E		townst use early)			
Date received:		e received:	or in	ternal use only) Received by:			
Bute received.		e received.		neceived by.			
Commission and Australia	1 /2-2-2	a:f., the weeks	١.				
Sample accepted / rejected (specify the reason):							
Sample processed by (name and stamp):							