PUSAT GENOM MANUSIA
HOSPITAL UNIVERSITI SAINS MALAYSIA

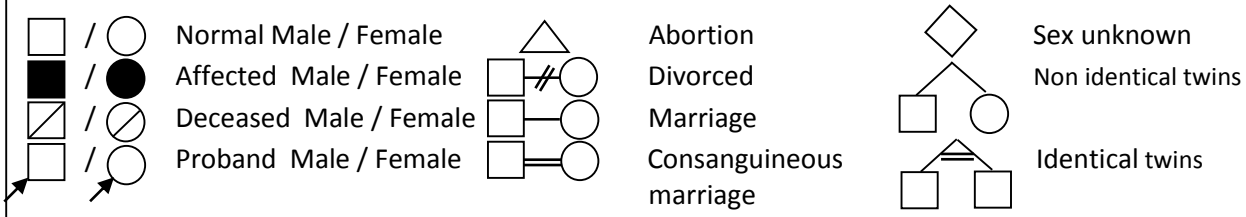
MOLECULAR DIAGNOSTIC TEST REQUEST FORM: GILBERT'S SYNDROME

Lab. No :

PATIENT'S PARTICULARS				
Name:		**RN:**	**IC no:**	
Sex:	**Age:**	**Date of birth:**	**Hosp/ Ward:**	
Address:				
Name of father:		**IC no:**	**Age:**	
Name of mother:		**IC no:**	**Age:**	
Family history of chromosomal/ genetic disorders: **Yes [ ] (If yes, please specify):** **No [ ]**				
Consanguinity: Yes [ ] Relationship: **No [ ]**				
Type of sample:	**Date and time of sampling:**			

PEDIGREE (PLEASE PROVIDE AT LEAST 3 GENERATIONS):

General symbols for pedigree diagram:



Clinical history	Clinical features / signs

:

Haemoglobin level	**g/dL**
Full Blood Picture (FBP)	**Haemolytic / Non-haemolytic**
Liver function test	

Clinical diagnosis:	**Name and stamp of specialist/consultant:** **Contact no :** **Email:**

PROCESSING LAB (For internal use only)		
Date received:	**Time received:**	**Received by:**
Sample accepted / rejected (specify the reason):		
Sample processed by (name and stamp):		