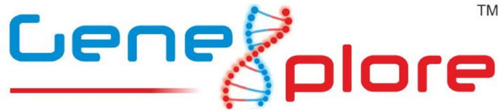

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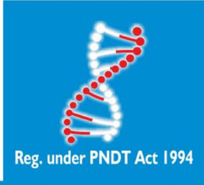
LAB ID



TEST REQUEST FORM

Date :

Patient Name : ______

Gender : ☐ M ☐ F ☐ UNKNOWN Age : ______ D.O.B. : / /

Contact No : ______ Email id : ______

Address : ______ City : ______

Clinical Diagnosis/History/Remarks: ______

Investigation : ______

Sample Type : ☐ EDTA BLOOD ☐ HEPARIN BLOOD ☐ AF ☐ POC ☐ OTHERS ______

Sample Collection Date : ______ **Time :** ______ AM/PM

Sample Temp. on Receipt ______

☐ **Pre test Counseling is preformed by** ______

I hereby, give consent to perform above mentioned Genetic test ☐ **Yes** ☐ **NO**

☐ **Post test counseling is performed by** ______

Referred by : Dr. ______ **Hospital Name :** ______

Mobile : ______ **Email id :** ______

Timings :- Monday to Saturday, 9.00 A.M to 7.00 P.M

Dr. Alpesh Patel
Cytogeneticist

Dr. Shiva Shankaran Chettiar
Molecular Geneticist

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