GENOMICS CLINICAL INFORMATION REQUISITION FORM (Form-20)

Patient's Name: .....Age/ Sex.....

Sample Collection Date: .....Time:…….

Lab No…….....Unique Patient ID (LPL) …….....

Tel. No: .....Ref. Doctor's Name: .....

Test Code Requested…….

Test Name Requested……

Sample Type……

Brief Clinical History……..

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MEDICAL HISTORY

Cardiovascular Diseases:		
Anemia / Lethargy	Yes	No
Palpitations (Chest discomfort)	Yes	No
Heart Attack / Angina (Chest Pain) / Myocardial Infarction	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Heart Valve Disease / History of Rheumatic Fever in childhood	Yes	No
Congestive Heart Failure	Yes	No
Coronary Heart Disease (Any history of angiogram / angioplasty)	Yes	No
Congenital Heart Disease (Atrial Septal Defect)	Yes	No
Respiratory Diseases:		
Asthma / COPD / Hay Fever / Allergies	Yes	No
Childhood Asthma	Yes	No
Emphysema / Difficulty in breathing	Yes	No
Positive TB Test	Yes	No
Gastrointestinal & Hepatobiliary Diseases:		
GERD (gastro esophageal reflux disease, frequent heart burn, burning sensation, belching)	Yes	No
Stomach Ulcers (diagnosed by endoscopy)	Yes	No
Hernia (congenital or acquired)	Yes	No
Colon Polyps	Yes	No
Hepatitis / Jaundice	Yes	No
Gall bladder Disease (stones)	Yes	No
Crohn's Disease	Yes	No
Neurological / Psychiatric Illness		
Alzheimer's Disease	Yes	No
Parkinson's Disease	Yes	No
Schizophrenia	Yes	No
Bipolar Disorder	Yes	No
Multiple sclerosis	Yes	No
Other Diseases:		
Kidney Stones	Yes	No
Type 1 Diabetes (Childhood)	Yes	No
Type 2 Diabetes (NIDDM)	Yes	No
Gestational Diabetes (Female only, pregnancy related)	Yes	No
Rheumatoid Arthritis	Yes	No
Psoriasis	Yes	No
Glaucoma	Yes	No
Age Related Macular Degeneration (AMD)	Yes	No
Hypothyroidism	Yes	No
Cancer	Yes	No

Does / did anyone in either your or your partner's family have any of the following?

(Please include yourself, your partner, your children, your parents, brothers, sisters, nieces, nephews, aunts, uncles, and grandparents)

	Yes	No	If Yes, Who
Mental retardation, learning disability, or autism?			
Down syndrome or other chromosome abnormality?			
Born with a heart defect?			
Born with cleft lip or palate			
Born with a neural tube defect (open spine, spina bifida or anencephaly)?			
Born with extra/missing fingers or toes or abnormality of arms, legs, hands or feet?			
Hearing problems or deafness (before age 60)?			
Serious eye problems or blindness?			
Hemophilia or a bleeding disorder?			
Neuromuscular disease or muscular dystrophy?			
Huntington disease?			
Cystic Fibrosis?			
Sickle Cell Disease?			
Miscarriages and/or stillbirths?			
Seizures or epilepsy?			
Any important psycho-social issue			

Signature / Thumb impression of Patient	***Signature of CC / PUP / Hospital***
Date :	***Date :***