INSTITUT PERUBATAN DAN PERGIGIAN TERMAJU (IPPT)
UNIVERSITI SAINS MALAYSIA (USM)

Advanced Diagnostic Laboratory

CHROMOSOMAL STUDIES FOR PERIPHERAL BLOOD

Name : Sex : ☐ Male ☐ Female ☐ Unknown

PID : Age :

I/C no. : D.O.B:

Date of specimen : Time of specimen taken:

Ward/Clinic : Hospital :

Type of sample :

For Laboratory Use Only

Master Lab No. :

Unit Lab No. :

Father's Name: Age:

Mother's Name: Age:

Consanguity : ☐ No ☐ Yes

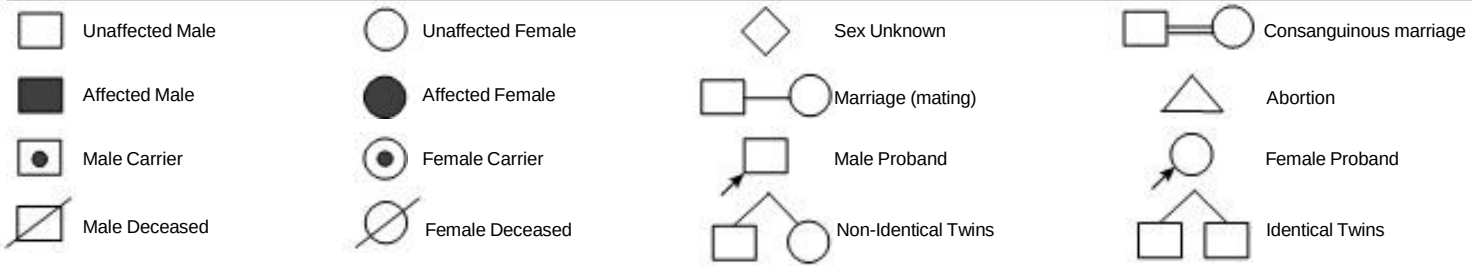
(Please state the relationship)

FAMILY HISTORY

Number of siblings: Death in siblings (including abortion):

Family history of known chromosomal/genetics disorders :(Including blindness, mental retardation, muscular dystrophy, others)

Pedigree : (Please attached at least 3 generations)



MEDICATION

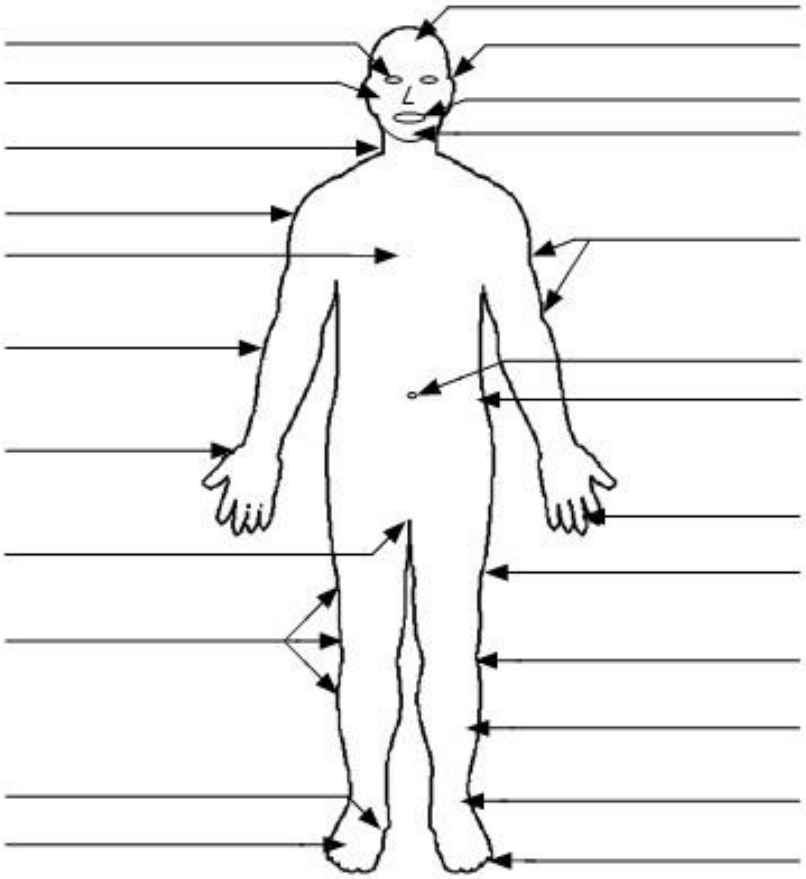
History of parental drug/addiction (for children) :

Drug/irradiation/chemotherapy in pregnancy (if any) :

REASONS FOR INVESTIGATION

Investigation of unrecognized/suspected syndrome/sex abnormality

Please specify major dysmorphic features observed clinically (Please use the diagram provided)



Confirmation of known syndrome

(Please specify)

TEST REQUESTED

Date & Time specimen collected : _____ _____ am / pm

☐ Cytogenetics / karyotyping ☐ SRY-Gene ☐ Molecular Studies : SAO ☐ FISH
Please state.....

Signature and stamp of Specialist / Medical Officer:

Telephone :

Note:

To avoid unnecessary waste of time and efforts, request for genetics investigation should be discussed with the consultant and confirm your appointment before collecting the specimen. For details, please contact us at telephone number 04-5622692. Please provide your contact number / extension to enable us to provide prompt feedback.

For laboratory use only.

Processed by :

No. of cell counted:

RESULT:

CYTOGENETICIST / SPECIALIST

DATE REPORT