labassure

AGILE
Advanced Genomics Institute & Laboratory mEdicine

Requisition Form (RF-100)

PATIENT INFORMATION			FOR LAB USE ONLY:
First Name:		Last Name:	Accession No:
Father's / Spouse Name:			Specimen ID:
Date of Birth: DD - MM - YYYY		Age:	Date & Time received:
Gender: Male ☐	Female ☐	Unknown ☐	Collection Centre:
Address & Contact Information:(Mandatory for prenatal Sample)			
			Account Number:
City:	State:	Pin Code:	
Email-ID:		Phone:	Payment :Cash / Check / Billing

PHYSICIAN INFORMATION	
Name:	**Institution:**
Phone:	**Email ID:**

TEST ORDERED (Mention code from test list)	SPECIMEN TYPE	
	☐ Amniotic Fluid	☐ DNA
	☐ Blood - SST	☐ FFPE/Tumour Block
	☐ Blood – Plain Vial	☐ NIPS Vial
	☐ Blood – Sod. Heparin	☐ Serum
	☐ Blood – EDTA	☐ Slides
	☐ Bone Marrow – Sod. Heparin	☐ Sputum
	☐ Bone Marrow – EDTA	☐ Tissue in _____
	☐ Chorionic Villi (CVS)	☐ Urine
	☐ Cord Blood	☐ Others
	☐ CSF	

DATE OF COLLECTION:

SEROLOGY REPORT (If Available):		
☐ HBs Ag Reactive/Non- reactive	☐ HCV Reactive/Non-reactive	☐ HIV Reactive/Non-reactive

FOR MATERNAL SCREENING (Dual/Triple/Quad Marker)			
Ultrasound Date and Copy:	CRL:	NT:	Fetal details:Single/Twin/Multiple
LMP:	EDD:	Weight(in Kg):	Body Height(in cm) :
Gestational Age:	Ethnicity:	Gravida(n):	Parity(n):
Patient on HCG dose: Yes☐ No☐ If Yes,last dose on :		Smoking: Yes / No	

PREVIOUS TEST RESULTS RELEVANT FOR CURENT TESTING

INDICATIONS FOR STUDY

SAMPLES TO BE DISPATCHED TO:

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