



GENETIC TEST REQUEST FORM

PATIENT DETAILS:

Surname: _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____

Forname: _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____

Date of Birth: _____/_____/_____ Sex: Male: Female: Hospital/Clinic No.: _____

Laboratory No.: _____ WARD: _____ Physician: _____

CLINICAL DETAILS (INCLUDING ANY FAMILY HISTORY):

PLEASE ATTACH CONSENT FORM TO THIS REQUEST

GENETIC PROFILES

Profile Name:	Code	Please ✓	Profile Name	Code	Please ✓
Genetic Profile 1	EX9	<input type="checkbox"/>	Genetic Profile 3	EX11	<input type="checkbox"/>
Genetic Profile 2	EX10	<input type="checkbox"/>	Genetic Profile 4	EX4	<input type="checkbox"/>

GENETIC TESTS

TEST Name:	Code	Please ✓	TEST Name:	Code	Please ✓
Angelman's Syndrome	ANGEL (9005I; 9090I)	<input type="checkbox"/>	Haemochromatosis	HFE (C282Y+H63D) (4190; 4198)	<input type="checkbox"/>
Chromosome Analysis / Karyotyping - Whole Blood	KARY (9005I)	<input type="checkbox"/>	MTHFR Mutation c677T	MTHFR (4185)	<input type="checkbox"/>
Chromosome Analysis - Products of Conception	(9031I)	<input type="checkbox"/>	Muscular Dystrophy (Duchenne's)	DUCH (7112)	<input type="checkbox"/>
Chromosome Y Microdeletions	(9050)	<input type="checkbox"/>	Philadelphia Chromosome	(4080)	<input type="checkbox"/>
Cystic Fibrosis Screen (36 mutations)	CF36 (9044E)	<input type="checkbox"/>	Prader Willi Syndrome (15q11-13 Methylation)	PRADW (9038)	<input type="checkbox"/>
DiGeorge Syndrome	(9005I; 9090I)	<input type="checkbox"/>	Prothrombin (Factor II) Mutation	PTMUT (4187)	<input type="checkbox"/>
Factor V Leiden PCR	FAC5 (4184)	<input type="checkbox"/>	Rett's Syndrome	9137E	<input type="checkbox"/>
Fragile X Chromosome	FRAGX (9060)	<input type="checkbox"/>	William's Syndrome,	WILL (9005I; 9090I)	<input type="checkbox"/>

OTHER TESTS REQUIRED:

Specimen Collection Date: _____/_____/_____

Specimen Type: _____

REQUESTING HOSPITAL/CLINIC DETAILS:

HOSPITAL/CLINIC NAME: _____ **DEPT:** _____

ADDRESS: _____

PHONE: _____

FAX: _____

Claymon Laboratories Limited, Three Rock Road, Sandymount Business Estate, Dublin 18.

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Page 1 of 1