



Prenatal Diagnostic Laboratory, Tsan Yuk Hospital

Address: Rm. 210, 30 Hospital Road, Hong Kong Tel: 25892218 Fax: 25172373



REQUEST FORM FOR LABORATORY STUDIES PRENATAL DIAGNOSIS / REPRODUCTIVE MEDICINE INVESTIGATION

PATIENT DETAILS	REFERRING DOCTOR DETAILS
Clinic / Hospital No.: _____	Name (Print / Staff Name Chop) _____
Surname / Last Name _____ <small>(please affix gum label or complete in full)</small> 中文姓名 _____	Tel: _____ Fax: _____
Given Name(s) / First Name(s) _____	Address: _____
HKID / Document ID _____	Referring institute _____
Date of Birth (DD-MM-YYYY) _____	Ward / Clinic _____
Age _____	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Consanguinity? _____	
PDC No.: _____	
Wife of / Husband of / Partner of: _____ <small>(Please delete where appropriate)</small>	

SPECIMEN DETAILS	Previous Report No. _____
Date & Time of Sampling DD-MM-YYYY,(HH:MM) _____	
<input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Chorionic villi <input type="checkbox"/> Placental tissue <input type="checkbox"/> Skin biopsy <input type="checkbox"/> Products of gestation	
<input type="checkbox"/> Foetal blood <input type="checkbox"/> Maternal blood <input type="checkbox"/> Paternal blood <input type="checkbox"/> Peripheral blood <input type="checkbox"/> Others: _____	

TESTS REQUESTED		
<input type="checkbox"/> Chromosomal microarray	<input type="checkbox"/> Karyotype	<input type="checkbox"/> Genetic testing for _____
<input type="checkbox"/> QF-PCR for chromosome	<input type="checkbox"/> Y-microdeletion	<input type="checkbox"/> UPD testing for chromosome _____
<input type="checkbox"/> 13 <input type="checkbox"/> 18 <input type="checkbox"/> 21	<input type="checkbox"/> Fragile X testing	<input type="checkbox"/> Methylation PCR for _____
<input type="checkbox"/> XY <input type="checkbox"/> Del22q11.2		<input type="checkbox"/> FISH for _____
		<input type="checkbox"/> Others: _____
		<input type="checkbox"/> Save DNA <input type="checkbox"/> Cryo-freeze cells <input type="checkbox"/> Keep cells in culture (1 month)

CLINICAL DETAILS		L.M.P.: _____	E.D.C. by scan: _____	Gestation _____ wk d
For prenatal diagnosis:		DD-MM-YYYY	DD-MM-YYYY	by scan: _____
<input type="checkbox"/> Abnormal DS screening: HA / private, 1 st tri / 2 nd tri DS, Risk 1 in _____		Report No.: _____		
<input type="checkbox"/> NIPT: HA / private, result _____		Report No.: _____		
<input type="checkbox"/> Anxiety <input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Translocation carrier <input type="checkbox"/> α thalassaemia couple <input type="checkbox"/> β thalassaemia couple				
<input type="checkbox"/> Previous child with chromosome abnormality: _____				
<input type="checkbox"/> Family history of chromosomal/genetic disorder: _____				
<input type="checkbox"/> Others: _____				
Ultrasound findings:				
Neurological:	Cardiac:	Gastrointestinal:	Genitourinary:	
<input type="checkbox"/> Abnormal gyration	<input type="checkbox"/> Aortic atresia <input type="checkbox"/> ASD	<input type="checkbox"/> Absence of stomach bubble	<input type="checkbox"/> Ambiguous genitalia	
<input type="checkbox"/> Agenesis of the corpus callosum	<input type="checkbox"/> Atrioventricular canal defect	<input type="checkbox"/> Anal atresia	<input type="checkbox"/> Congenital posterior urethral valves	
<input type="checkbox"/> Cerebellar hypoplasia	<input type="checkbox"/> Coarctation of the aorta	<input type="checkbox"/> Ascites	<input type="checkbox"/> Hydronephrosis	
<input type="checkbox"/> Dandy Walker malformation	<input type="checkbox"/> Dextrocardia	<input type="checkbox"/> Echogenic bowel	<input type="checkbox"/> Kidney malformation	
<input type="checkbox"/> Decreased fetal movement	<input type="checkbox"/> Double outlet right ventricle	<input type="checkbox"/> Gastrochisis	<input type="checkbox"/> Megacystis	
<input type="checkbox"/> Holoprosencephaly	<input type="checkbox"/> Ebstein anomaly	<input type="checkbox"/> Meconium ileus	<input type="checkbox"/> Polycystic kidneys	
<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Echogenic intracardiac focus	<input type="checkbox"/> Omphalocele	<input type="checkbox"/> Renal agenesis	
<input type="checkbox"/> Neural tube defect	<input type="checkbox"/> Hypoplastic left heart	<input type="checkbox"/> Tracheoesophageal fistula	<input type="checkbox"/> Urethral obstruction	
<input type="checkbox"/> Ventriculomegaly	<input type="checkbox"/> Hypoplastic right heart	<input type="checkbox"/> Others: _____	<input type="checkbox"/> Ureteral obstruction	
<input type="checkbox"/> Others: _____	<input type="checkbox"/> Pulmonary valve atresia		<input type="checkbox"/> Others: _____	
	<input type="checkbox"/> Situs inversus			
	<input type="checkbox"/> Tetralogy of Fallot			
	<input type="checkbox"/> Transposition of the great vessels	Musculoskeletal:		
	<input type="checkbox"/> Truncus arteriosus <input type="checkbox"/> VSD	<input type="checkbox"/> Abnormal vertebral morphology	Others :	
	<input type="checkbox"/> Others: _____	<input type="checkbox"/> Abnormal thorax morphology	<input type="checkbox"/> Fetal cystic hygroma	
Craniofacial:		<input type="checkbox"/> Acromelia	<input type="checkbox"/> Hydrops fetalis	
<input type="checkbox"/> Aplasia/Hypoplasia of nasal bone		<input type="checkbox"/> Club foot <input type="checkbox"/> Clenched hands	<input type="checkbox"/> Increased nuchal translucency (_____ mm)	
<input type="checkbox"/> Cleft lip		<input type="checkbox"/> Contractures (arthrogryposis)	<input type="checkbox"/> IUGR	
<input type="checkbox"/> Cleft lip and cleft palate		<input type="checkbox"/> Limb anomaly	<input type="checkbox"/> Oligohydramnios	
<input type="checkbox"/> Cleft palate		<input type="checkbox"/> Mesomelia <input type="checkbox"/> Micromelia	<input type="checkbox"/> Polyhydramnios	
<input type="checkbox"/> Hypertelorism	Pulmonary:	<input type="checkbox"/> Polydactyly <input type="checkbox"/> Syndactyly	<input type="checkbox"/> Single umbilical artery	
<input type="checkbox"/> Hypotelorism	<input type="checkbox"/> CPAM	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Others: _____	
<input type="checkbox"/> Macrocephaly	<input type="checkbox"/> Diaphragmatic eventration	<input type="checkbox"/> Short long bone		
<input type="checkbox"/> Microcephaly	<input type="checkbox"/> Diaphragmatic hernia	<input type="checkbox"/> Skeletal dysplasia		
<input type="checkbox"/> Others: _____	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Others: _____		
	<input type="checkbox"/> Pulmonary sequestration			
	<input type="checkbox"/> Others: _____			

For reproductive medicine investigation:		
<input type="checkbox"/> Recurrent pregnancy loss	<input type="checkbox"/> Primary ovarian insufficiency	<input type="checkbox"/> Severe male factors
<input type="checkbox"/> Family history of chromosomal disorder: _____		(Previous Report No.: _____)
<input type="checkbox"/> Others: _____		

Please complete the patient consent form and return it to the laboratory with this request form.

Referring doctor's signature: _____	Request date DD-MM-YYYY: _____
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Name: _____

HKID / Document ID: _____

(or GUM LABEL)

LABORATORY USE ONLY

Duty Officer:

Date and Time of sample receipt: