Centre for Human Genetics

DNA Test Request Form

DATE :

PATIENT NAME: ……..

DOB/SEX : …….....

REFERRING CLINICIAN: ……

HOSPITAL: …….

REFFERAL NO: …….

SAMPLE TYPE: PB/CB/AF/CVS …….

TEST REQUIRED: ……....

TENTATIVE DIAGNOSIS/ CLINICAL DETAILS:

……

……

……

ATTACHED REPORTS IF AVAILABLE :

DD NUMBER : ……..

Biotech Park, Next to Arvind Mills, Electronic Phase I, Bangalore-560066

Tel: 080-28521833 Fax: 080-28521832

Centre for Human Genetics

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REFERRING CLINICIAN

NAME : ……..

PHONE NUMBER : ……..

E MAIL ID: ……

REQUESTS/ REMARKS : …….

……

SIGNATURE:

NOTE :

- ***BLOOD SAMPLE TO BE SENT IN EDTA VACUTAINER.***
- ***PLEASE SEND THE DD/CHEQUE/CASH FOR THE TEST ALONG WITH THE SAMPLE.***

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- ***INCOMPLETE FORMS WITHOUT PAYMENT WILL NOT BE PROCESSED.***
- ***IF ANY DISCOUNT IS BEING REQUESTED, THE CLINICIANS REQUEST AND ATTESTATION FOR SUCH SHOULD BE FILLED AND SIGNED.***
- ***PLEASE ATTACH ANY RELAVENT REPORTS.***

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