Bumrungrad International HOSPITAL

Genetic Screening Request Form

แบบฟอร์มการสั่งตรวจทางอณูพันธุศาสตร์

**Please complete all information below.
Test will not be performed without completed requisition form**

Patient Information

Specimen MUST be labeled with patient First Name, Last name, Date of birth and Date of collection

Patient First Name : (ชื่อไทย) _____

Last Name : (นามสกุลไทย) _____

H.N. _____ Date of Birth (dd/mm/yy _____/_____/____ Gender ◯ Male ◯ Female

Tel : _____ E-mail : _____

Ship To

Laboratory Department, Fl.4 Building B

33 Sukhumvit 3, Wattana, Bangkok, Thailand 10110

Tel:+6620114158

Labservices@bumrungrad.com

	GENETIC TEST		Specimen type
☐	092-10-0024	APOE (for Cardiovascular Disease)	EDTA Whole blood 3 ml. or Buccal swab 1 tube
☐	092-10-0025	APOE Genotype (Risk for Alzheimer Disease)	EDTA Whole blood 3 ml. or Buccal swab 1 tube
☐	LAB13	Advanced lipid I (Apo A1, ApoB, Lipo (a), CRP, sLDL)	Serum 2 ml. or Plain blood 6 ml
☐	LAB14	Advanced lipid II (Apo A1, ApoB, Lipo (a), CRP, sLDL, APOE))	Serum 2 ml. and EDTA Whole blood 3 ml. or Serum 2 ml. and Buccal swab 1 tube
☐	Other	_____	

	VITAMIN PROFILE		Specimen type
☐	098-10-0008-01	25-OH Vitamin D3/D2 by LC-MS/MS	Serum 1.5 ml. or Plain blood 6 ml
☐	098-11-0209	Vitamin B1	EDTA Whole blood 3 ml.
☐	098-11-0210	Vitamin B2	EDTA Whole blood 3 ml.
☐	098-11-0211	Vitamin B6	EDTA Whole blood 3 ml.
☐	VITCVTL	Vitamin C	Serum 1.5 ml. or Plain blood 6 ml
☐	VITAMINA	Vitamin A	Serum 1.5 ml. or Plain blood 6 ml
☐	VITAMINC	Vitamin E	Serum 1.5 ml. or Plain blood 6 ml

	ANTIOXIDANTS		Specimen type
☐	090-21-1582	Glutathione, HPLC **	EDTA Whole blood 3 ml.

	FOOD INTOLERANCE		Specimen type
☐	098-10-0040	Food Intolerance IgG (221 Allergens)	Serum 2 ml or Plain blood 6 ml

Specimen Collection

Collection Date (dd/mm/yyyy) _____

Collection Time (hh/mm) _____

Referring Physician : ข้อมูลแพทย์ผู้สั่งตรวจ

Referring Physician Name: _____

Tel : _____ E-mail : _____

Referring Clinic : _____ Referring Clinic contact pers _____

Tel : _____ E-mail : _____

For sending report

Signature Referring Physician : _____