

GENERAL LABORATORY TEST REQUEST FORM

Lab. No / Barcode

Patient Details

Name : _____
 IC/ Passport No. : _____
 DOB : _____
 Age : _____ Gender : _____
 Your Reference : _____

Referring Doctor's Name & Address (Stamp)

Clinical History & Diagnosis

Specimen Type

Blood
 Urine
 Faeces
 Sputum
 Blood Culture Vial

Fluids:
Pls specify: _____ Date of Sample Taken: _____
 Others:
Pls specify: _____
 Swab
Pls specify: _____ Time of Sample Taken: _____ AM/PM

Profile Tests <input type="checkbox"/> Renal Profile 1 <input type="checkbox"/> Renal Profile 2 <input type="checkbox"/> Liver Profile <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Anaemia Studies <input type="checkbox"/> Hypertensive Profile <input type="checkbox"/> Thyroid Profile <input type="checkbox"/> Arthritis Profile <input type="checkbox"/> Cardiac Enzymes Profile <input type="checkbox"/> Infertility Profiles 1 <input type="checkbox"/> Infertility Profiles 2 <input type="checkbox"/> Pre-op Screening Profile <input type="checkbox"/> Dengue Profile <input type="checkbox"/> STD Profile 1 <input type="checkbox"/> STD Profile 2	Biochemistry <input type="checkbox"/> Amylase <input type="checkbox"/> AST <input type="checkbox"/> ALT <input type="checkbox"/> Calcium <input type="checkbox"/> Creatinine <input type="checkbox"/> Glucose <input type="checkbox"/> Urea <input type="checkbox"/> Uric Acid Fluid Excretion <input type="checkbox"/> Urine Analysis	Haematology <input type="checkbox"/> Full Blood Count <input type="checkbox"/> Full Blood Picture <input type="checkbox"/> Peripheral Blood Film <input type="checkbox"/> White Blood Cell <input type="checkbox"/> Hemoglobin <input type="checkbox"/> Platelet Count <input type="checkbox"/> ESR <input type="checkbox"/> Blood Grouping & Rh Coagulation <input type="checkbox"/> Coagulation Profile 1 <input type="checkbox"/> Coagulation Profile 2 <input type="checkbox"/> DIC Screen <input type="checkbox"/> PT / INR <input type="checkbox"/> APTT <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Thrombin Time <input type="checkbox"/> D-Dimer	Serology <input type="checkbox"/> Dengue NS1 Ag <input type="checkbox"/> Dengue IgG/IgM <input type="checkbox"/> Leptospiral Ab <input type="checkbox"/> H. pylori Ab <input type="checkbox"/> Mycoplasma Ab Special Chemistry <input type="checkbox"/> Free T4 <input type="checkbox"/> Free T3 <input type="checkbox"/> TSH <input type="checkbox"/> Beta-HCG <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Ferritin <input type="checkbox"/> Folate	Infectious Diseases <input type="checkbox"/> Hepatitis Bs Antigen <input type="checkbox"/> Hepatitis Bs Antibody <input type="checkbox"/> Hepatitis A IgG <input type="checkbox"/> Hepatitis A IgM <input type="checkbox"/> Hepatitis C Antibody <input type="checkbox"/> HIV Ag / Ab Combo <input type="checkbox"/> Syphilis Screening (TP) Tumours Markers <input type="checkbox"/> CEA <input type="checkbox"/> AFP <input type="checkbox"/> CA125 <input type="checkbox"/> CA15-3 <input type="checkbox"/> CA19-9 <input type="checkbox"/> PSA Total
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Other Tests (Pls Specify)

Result Delivery

Phone : _____
 Email : _____
 Fax No: _____

For Neogenix Laboratoire Use only

Despatch Name : _____
 Received by (Name) : _____
 Date & Time received : _____

Payment Method (if applicable)

Cash Online Transfer Other: _____

Bank details:

RHB Bank Berhad
 Beneficiary name: Neogenix Laboratoire Sdn Bhd
 Account No: 2124 3960 0328 27

*Please provide the payment proof (bank slip) if payment is done via online transfer