

LABORATORY TEST REQUEST FORM

For NeoGenix Laboratoire use only

Referring Doctor's Name & Hospital Stamp

Patient Details

Name : _____
IC/Passport No : _____
Date of Birth : _____
Age : _____ **Sex** : _____
Your reference : _____

Clinical History & Diagnosis

Type of Specimen

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood in EDTA tube | <input type="checkbox"/> Sputum | <input type="checkbox"/> Rectal swab |
| <input type="checkbox"/> Blood in heparin tube | <input type="checkbox"/> Broncho-alveolar lavage | <input type="checkbox"/> Other swab: _____ |
| <input type="checkbox"/> CSF | <input type="checkbox"/> Nasopharyngeal swab | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stool | <input type="checkbox"/> Cervical swab | |
| <input type="checkbox"/> Urine | <input type="checkbox"/> Liquid based cytology specimen | |

Date of Sample Taken: _____ Time of Sample Taken: _____ AM/PM

Test Requested

- | | | | |
|--|--|---|---|
| <u>Immunosuppression Panels</u> | <u>Gastrointestinal Panels</u> | <u>Respiratory Panels</u> | <u>Blood Borne</u> |
| <input type="checkbox"/> BKV and CMV Combo assay | <input type="checkbox"/> RPGPP | <input type="checkbox"/> RP-26 | <input type="checkbox"/> HIV viral load |
| <input type="checkbox"/> CMV viral load | <input type="checkbox"/> GPP | <input type="checkbox"/> Flu A/B & RSV Panel | <input type="checkbox"/> HCV viral load |
| <input type="checkbox"/> BKV viral load | <input type="checkbox"/> GPP-Bacterial I | <input type="checkbox"/> RV-19 | <input type="checkbox"/> HBV viral load |
| <input type="checkbox"/> EBV viral load | <input type="checkbox"/> GPP-Bacterial II | <input type="checkbox"/> RB-7 | |
| <input type="checkbox"/> Adenovirus viral load | <input type="checkbox"/> GPP-Virus | | |
| <input type="checkbox"/> Quantiferon Monitoring Assay | <input type="checkbox"/> GPP-Parasite | | |
| <input type="checkbox"/> Quantiferon CMV Assay | | | |
| <u>TB Testing</u> | <u>STD</u> | <u>Mycology</u> | <u>Woman Health</u> |
| <input type="checkbox"/> TB PCR | <input type="checkbox"/> STI-7 | <input type="checkbox"/> <i>Aspergillus</i> Galactomannan Assay | <input type="checkbox"/> HPV Screening |
| <input type="checkbox"/> TSPOT-TB | <input type="checkbox"/> STI-Genital Ulcer | <input type="checkbox"/> Molecular Id (Mold & Yeast) | <input type="checkbox"/> HPV Genotypng |
| <input type="checkbox"/> Quantiferon TB Gold Plus | <input type="checkbox"/> STI Combo Assay | | |
| <u>Others</u> | | | |
| <input type="checkbox"/> Meningitis/Encephalitis Panel | | | |
| <input type="checkbox"/> Sepsis Panel | | | |
| <input type="checkbox"/> PCR Identification of Rare Bacteria | | | |
| <input type="checkbox"/> Specify: _____ | | | |

Result Delivery

- Phone : _____
 Email : _____
 Fax No: _____

For Neogenix lab use only

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

Payment Method (if applicable)

- Cash Online Transfer Others: _____
*Please provide the payment proof (bank slip) if payment is done via online transfer

Bank details:

Maybank Berhad
Beneficiary name: Neogenix Laboratoire Sdn Bhd
Account No: 5123 5261 8239