



Asiri Centre for Genomic and Regenerative Medicine

Asiri Surgical Hospital, Kirimandala Mawatha, Colombo 5, Sri Lanka

94 -011-4524400 ext 2514/2503, acgrm@asiri.lk

Request Form For Genetic Testing

Hospital/Ward/Clinic:			
Clinic/BHT No:		Date:	
Referring Doctor's Name/Designation:			
Contact Phone No:			
Patient Name:			
Date of Birth/Age:		Sex:	
Patient's Address:			
Contact Phone No:			
Specimen Type:	Peripheral Blood <input type="checkbox"/>		
	Other Tissue (Please Specify):		
Test Requested:	Chromosome Culture & Karyotyping <input type="checkbox"/>		
	Other Test (Please Specify):		
Indication:			

Other Clinical Details (Including History of Any Illness in Family Members)

.....

.....

.....

.....

.....

It is necessary that the referring doctor provide **pre-test counselling** to the patient and obtain **written informed consent** before sending a sample for testing. An informed consent form is enclosed for this purpose. Please ensure that it is filled and signed by the patient and the doctor. **If you need assistance then please do not hesitate to contact us.** Samples sent without the consent form will not be processed until we receive the consent form.