

BLOOD FOR CHROMOSOME ANALYSIS

ADULTS - 4ml Blood	} - Collect in Green-Top Vacutainer Tube	FIRST <input type="checkbox"/>	REPEAT <input type="checkbox"/>
CHILDREN - 1-4ml Blood		PREVIOUS LAB No. <input type="text"/>	
BABIES Under 1 Month - Full Paediatric Tube			

52 Siphosethu Road
Mt. Edgecombe,
4302
Tel: (031) 719 6607
Emerg. No. 082 894 0752
Website: www.sanbs.co.za



Opening Hours:-
Monday - Friday
08h00 - 16h00

PLEASE TICK TESTS REQUESTED		N.B. Blood will not be processed unless this form is completed in every detail and the tube is labelled.
<input type="checkbox"/> KARYOTYPING	<input type="checkbox"/> QF - PCR	

PATIENT INFORMATION							
SURNAME							
FIRST NAME							
IDENTITY NUMBER	DATE OF BIRTH <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y
D	D	M	M	Y	Y		
PATIENT CELL No.	<input checked="" type="checkbox"/> SEX <table border="1"><tr><td>M</td><td>F</td></tr></table> AGE:	M	F				
M	F						
FOR CHILDREN: How old was the mother when the child was born?	AGE:						

FOR LAB USE ONLY

LABORATORY NUMBER

SAP BARCODE

HOSPITAL DETAILS	
NAME OF HOSPITAL	TEL. No.
ADDRESS:	SPECIMEN COLLECTION
PATIENT HOSPITAL NUMBER:	DATE:
REFERRING DOCTOR:	TIME:
EMAIL ADDRESS:	WARD:
SIGNATURE:	DOCTORS CELL No. :

MEDITECH STICKER

MEDICAL AID DETAILS	
IS PATIENT A MEMBER OF MEDICAL AID?	YES NO MEDICAL AID SOCIETY:
MEDICAL AID NUMBER:	
ACCOUNT DETAILS - ADDRESS	NAME OF PRINCIPAL MEMBER OF MEDICAL AID / GUARANTOR:
ADDRESS OF GUARANTOR:	
	POSTAL CODE: TEL. (H):
EMPLOYER	TEL. (B):

PERSON PROCESSING
VOLUME RECEIVED
DATE PROCESSED

PROVISIONAL DIAGNOSIS	
PAEDIATRIC	ADULT
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Sex Chromosome Abnormality
<input type="checkbox"/> Trisomy 13/18	<input type="checkbox"/> Down Syndrome in Family
<input type="checkbox"/> Ambiguous Genitalia	<input type="checkbox"/> Multiple Miscarriages
<input type="checkbox"/> Dysmorphic Features	<input type="checkbox"/> Amenorrhoea
<input type="checkbox"/> Multiple Congenital Abnormalities	<input type="checkbox"/> Infertility
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Turner Syndrome
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

NON-CONFORMING SPECIMENS

Clinical Details:

BLOOD CHROMOSOME ANALYSIS - This analysis takes approximately 20 working days to complete. Results will be posted to the referring doctor.

FOR LABORATORY USE ONLY	
Cell Culture: Blood 4750	Blood Karyotyping 4754
Additional Staining Procedure 4757	Additional Analysis: Mosaicism 4757

PLEASE NOTE: SANBS shall take reasonable steps to keep your personal information confidential, safe, protected and secure and shall under no circumstances, publish, issue, circulate, distribute or share it with third parties in any form, unless authorised and/or required and/or allowed in terms of law, regulation, standard, directive, ruling, guideline, notice, or by-law.