Prenatal Diagnostic Laboratory, Tsan Yuk Hospital

Address: Rm. 210, 30 Hospital Road, Hong Kong Tel: 25892218 Fax: 25172373

HKU Med School of Clinical Medicine
Department of Obstetrics & Gynaecology
香港大學婦產科學系

REQUEST FORM FOR POSTNATAL STUDIES

PATIENT DETAILS

Clinic / Hospital No.:

(please affix gum label or complete in full)

Surname / Last Name 中文姓名

Given Name(s) / First Name(s)

HKID / Document ID **Date of Birth** (DD-MM-YYYY) **Age**

Gender: ☐Female ☐Male ☐Uncertain

Relationship to proband:

Proband's name and ID:

REFERRING DOCTOR DETAILS

Name (Print / Staff Name Chop)

Tel: Fax:

Address:

Referring institute Ward / Clinic

SPECIMEN DETAILS

Date & Time of Sampling (DD-MM-YYYY,(HH:MM))

Previous Report No.

☐Peripheral blood: ___ tubes *(2 mL Heparin blood)*, ___ tubes *(3 mL EDTA blood)*

☐Skin biopsy ☐Others, please specify:

TESTS REQUESTED

☐Karyotype

☐Chromosomal microarray

QF-PCR for chromosome
☐13 ☐18 ☐21
☐XY ☐Del22q11.2

☐ Fragile X testing

☐Genetic testing for

☐UPD testing for chromosome

☐Methylation PCR for

☐FISH for

☐Others:

CLINICAL DETAILS

Prenatal diagnosis result (if any):

Perinatal History:
☐IUGR
☐Oligohydramnios
☐Polyhydramnios
☐Premature delivery
☐Others:

Growth:
☐Failure to thrive
☐Growth delay
☐Increase body weight
☐Obesity
☐Short stature
☐Others:

Developmental:
☐Fine motor delay
☐Gross motor delay
☐Speech delay
☐Others:

Cognitive:
☐Intellectual disability
☐Specific learning disability
☐Others:

Other features:

Behavioral:
☐Autistic behavior
☐Autism spectrum disorder
☐Obsessive-compulsive disorder
☐Oppositional defiant disorder
☐Others:

Neurological:
☐Anomaly of the brain
☐Central hypotonia
☐Cerebral palsy ☐Chorea
☐Dystonia ☐Gait ataxia
☐Muscular hypotonia
☐Neural tube defect
☐Spasticity
☐Others:

Craniofacial:
☐Cleft lip
☐Cleft lip and cleft palate
☐Cleft palate
☐Coloboma of iris and retina
☐Craniosynostosis
☐Dysmorphic facial features
☐External ear malformations
☐Macrocephaly
☐Microcephaly
☐Others:

Cardiac:
☐Aortic atresia ☐ASD
☐Atrioventricular canal defect
☐Coarctation of the aorta
☐Dextrocardia
☐Double outlet right ventricle
☐Ebstein anomaly
☐Echogenic intracardiac focus
☐Hypoplastic left heart
☐Hypoplastic right heart
☐Pulmonary valve atresia
☐Situs inversus
☐Tetralogy of Fallot
☐Transposition of the great vessels
☐Truncus arteriosus ☐VSD
☐Others:

Gastrointestinal:
☐Gastroschisis
☐Hirschsprung disease
☐Omphalocele
☐Pyloric stenosis
☐Tracheoesophageal fistula
☐Others:

Cutaneous:
☐Hyperpigmentation
☐Hypopigmentation
☐Others:

Musculoskeletal:
☐Abnormal vertebral morphology
☐Abnormal limb ☐Club foot
☐Diaphragmatic hernia
☐Limb contractures
☐Polydactyly ☐Syndactyly
☐Scoliosis
☐Others:

Genitourinary:
☐Ambiguous genitalia
☐Hydronephrosis
☐Hypospadias
☐Kidney malformation
☐Undescended testis
☐Urethral malformation
☐Ureteral obstruction
☐Others:

Family History:
☐Family history of chromosomal / genetic disorder:

☐Parents with ≥ 2 miscarriages
☐Relatives with similar clinical history (please explain):

Please complete the patient consent form and return it to the laboratory with this request form.

Referring doctor's signature: **Request date** (DD-MM-YYYY) :

LABORATORY USE ONLY Duty Officer:

Date and Time of sample receipt: