LABORATORY TEST REQUEST FORM

GENEFLUX BIOSCIENCES SDN BHD (769382-V)
GENEFLUX DIAGNOSTICS SDN BHD (891567-M)
CORPORATE HEAD OFFICE & LABORATORY ADDRESS:
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For Geneflux Laboratory Use Only

Doctor's Name :

Tel No. :

Clinic/Hospital Chop

Patient Details

MRN :

I/C No. : __ __

Name :

Date of Birth (dd/mm/yyyy) : / /

Sex : M F

Age : Month / Year

Clinical Summary / Diagnosis _____

Please Mark Box With X

PCR Test Requested

Respiratory	Blood Borne	Herpes virus	Arbovirus	
RP33	BK/JC viral load	EBV viral load	Dengue	Leptospirosis
H7N9	HBV viral load	CMV viral load	Dengue/ Chikungunya	MRSA
MERS-CoV	HCV viral load	VZV viral load	**STI**	Bukholderia pseudomallei (Meliodosis)
RV-16	HiV viral load	HSV 1&2 viral load	STI 7	Toxoplasma gondii
RB-7			STI 9	Tropical Fever Panel
Flu Panel (H1N1 RSV A/B)				HPV Others : _____

Type of Specimen

- Throat Swab
- Nasal Swab
- Nasopharyngeal Swab
- BAL
- Nasopharyngeal Secretion
- Blood in EDTA tube
- Blood in Plain tube
- Plasma
- Serum
- Sputum
- Tracheal Aspirate
- From Lesion
- Biopsy/Tissue
- Urine
- CSF
- Ocular fluid
- Others: _____

Specify site of swab: _____

Specify site of Biopsy: _____

Date of Sample Taken: / /

Time of sample Taken: : AM/PM

Hospital Lab

Sample Collected By: _____

Payment

Bill to Account Bill to Patient

Result delivery via:

Fax No. : _____

Email : _____

For Geneflux Lab use only

Despatch Name : _____

Received by (Name) : _____

Date & Time received: _____

Note: Sample pick-up : 8.00 AM - 5.30 PM