Neuberg DIAGNOSTICS | CENTER FOR GENOMIC MEDICINE

TEST REQUISITION FORM

DNA FINGER PRINTING/KINSHIP/PATERNITY

FIRST PERSON

Patient Photograph

Full Name _____

Sex ☐ Male ☐ Female ☐ Others **Age** _____ **Ethnicity** _____

Sample Information

Collection Date _____ **Time** _____ **Collected By** _____

Place of Collection _____ **Sample Type** ☐ EDTA ☐ Buccal Swab ☐ FTA Card

SECOND PERSON

Patient Photograph

Full Name _____

Sex ☐ Male ☐ Female ☐ Others **Age** _____ **Ethnicity** _____

Sample Information

Collection Date _____ **Time** _____ **Collected By** _____

Place of Collection _____ **Sample Type** ☐ EDTA ☐ Buccal Swab ☐ FTA Card

Mandatory Documents of Above Mentioned Person (Any One) :

☐ Aadhar Card ☐ Voter ID ☐ Birth Certificate ☐ Ration Card ☐ PAN Card

First Person and Second Person are ☐ **Blood Related** ☐ **Unrelated**

If related, please mention relationship

Declaration by the Donor/Guardian:

I/We_____Son/daughter/wife/under guardianship of Mr./Ms_____., hereby declare that the blood given to laboratory, is for DNA fingerprinting is of mine/of my/of our child did not receive a blood transfusion within last three months or any transplantation.

Signature or thumb impression of donor

Date:

Referring Doctor's signature & seal

Note:
1. About 2-3 ml of fresh blood should be collected in EDTA anticoagulant phial. The phial should be duly sealed, and transferred to the laboratory in cold icebox. Duly filled separate Identification forms should be sent for each donor
2. The specimen container should be labeled with name, I D No. , Date of collection & collector's initials. The label shall not be obscured, altered or removed
3. Enclose a copy of photo ID of the donor
4. Samples should be packed in sealed cover during transportation to the laboratory

Prepared by: QM	Approved by: Lab Director	Issued by: QM	Page No. 1 to 1	

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CHAIN OF CUSTODY RECORD

I (collector print name), _____, have verified each tested person for proper identification and documented appropriately, collected and labelled each sample accurately, as well as labelled each specimen clearly with the name, date of collection, and my initials. Also each specimen is sealed and has not been tampered with and never been left unattended.

Collector Signature: _____ **Date** _____

Organization/Company _____ **Contact Number** _____

Contact Address _____

Specimen shipped by: Collector Other (print name) _____

Organization/Company _____

PATIENT MEDICAL INFORMATION

Does the patient have an autoimmune disease (i.e.:Lupus) ☐ Yes ☐ No **If yes, specify** _____

Medical Diagnosis (specify) _____

Previous Transplant ☐ Yes ☐ No **Organ** _____ **Donor ID** _____ **Tx Date** _____

Did the patient receive blood products (ever) ? ☐ Yes ☐ No ☐ Unknown **Date last received** _____

Did the patient have pregnancies / miscarriages? ☐ Yes ☐ No ☐ Unknown **# of Pregnancies / Miscarriages** ☐

Did the patient receive any antibody based therapy (i.e. ATG, IVIg, Rituximab, Basiliximab, etc.)? ☐ Yes ☐ No

Specify _____ **Date last received** _____

Patient Name:

Date: **Place:**

Signature _____

Consultant Name:

Date: **Place:**

Signature _____

REMARKS

For office use only Rec'd Date & Time	Tech Initials	# ACD	# Clots	# Na Heparin	Comment

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