

Karyotyping (Chromosome Analysis) Clinical History Form

CLIENT CODE & CLIENT NAME: _____ Lab Reference No.: _____
 Accession No. (For Lab use only): _____
 Patient's Name Rupali Sagar Dalvi
 Date of Birth: 03/03/1995 Age: _____ years Gender: M/ F/ TG
 Date & Time of Sample Collection: 24/07/23

Clinician's Details

Name: Neslekar Leeb Karmaln Contact Number: 9423528537

Specimen Submitted

☐ Whole Blood ☐ Tissue ☐ Any Other whole Blood
 Indication of Test: M/O Abortion

Relevant Clinical History of Patient: _____

Consanguineous Marriage (Married to close relatives) ☒ Yes ☐ No

Number of Conceptions _____

No. of Births: — No. of Abortions: 11 Delivery: Children: Surviving — Expired —

Mother's Age at the time of Patient's Birth (Applicable for children) _____

- Congenital Deformity in Mother: ☐ Yes ☒ No
- If Yes, Please specify physical or mental

Father's Age at the time of Patient's Birth (Applicable for children) _____

- Congenital Deformity in Mother: ☐ Yes ☒ No
- If Yes, Please specify physical or mental

Family History of Congenital Defect (if applicable)

- Maternal Relatives ☐ Yes ☒ No if Yes Please Specify Physical or Material
- Paternal Relatives ☐ Yes ☒ No if Yes Please Specify Physical or Material

Any Congenital Deformity in Grandparents

- Maternal Relatives ☐ Yes ☒ No if Yes Please Specify Physical or Material
- Paternal Relatives ☐ Yes ☒ No if Yes Please Specify Physical or Material

No. of Siblings: Male: _____ Female: _____

Any Congenital deformity in Siblings: ☐ Yes ☒ No If Yes, Please Specify Physical or Material

24/07/23

Name & Signature of Patients / Guardian

Name & Signature of Requisitioner