

KHGLBS 770

46M

**TEST REQUISITION FORM/PATIENT INTAKE FORM**

Name: Gangadhar	Phone Number: 9885670124
Date of Sample collection:	Email:
Age/Gender: 46Y   Male	Referral Doctor/Hospital:
Address:	Pre-Counselor/ Sample Co-ordinator: Ravani.

**TEST NAME**

Whole Exome Sequencing (WES)	<input type="checkbox"/>	Clinical Exome Sequencing (CES)	<input type="checkbox"/>
WES + Mitochondrial Sequencing	<input type="checkbox"/>	CES + Mitochondrial Sequencing	<input type="checkbox"/>
Hereditary Cancer Screening (HCS)	<input type="checkbox"/>	Targeted Sequencing for Oncology	<input type="checkbox"/>
Sanger Sequencing	<input type="checkbox"/>	Whole transcriptome analysis (WTA)	<input type="checkbox"/>
mRNA analysis (mRNA seq)	<input type="checkbox"/>	small RNA seq	<input type="checkbox"/>
Others _____	<input type="checkbox"/>		

1. Indications for genetic testing:

2. Any Specific condition or genes to look for: PARKINSON'S +  
NEUROLOGICAL ISSUE.**SAMPLE TYPE**

Whole Blood in EDTA	<input checked="" type="checkbox"/>	Whole Blood In Heparin	<input type="checkbox"/>
Whole Blood in cfDNA Tubes	<input type="checkbox"/>	FFPE Blocks	<input type="checkbox"/>
Sputum	<input type="checkbox"/>	Swab/Specimen/Culture	<input type="checkbox"/>
Tissue (in PBS/Saline/RNA Later/Others)	<input type="checkbox"/>	Urine	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>		

**Current Complaints** *Treatment*

**Complaint 1:** Respiratory ~~ATC~~

a. Onset *Allegies*

b. Duration

**Complaint 2:** \_\_\_\_\_

a. Onset

b. Duration

**Complaint 3:** \_\_\_\_\_

a. Onset

b. Duration

## Reason for Genetic Testing?

Why do you want to do this genetic testing	
1	I want to know if there is any genetic cause for my Medical Condition. <input type="checkbox"/>
2	I want to know if there is any genetic cause for a symptom I have been having since a long time. <input type="checkbox"/>
3	My family or close relatives are having history of chronic disease. <input type="checkbox"/>
4	There is a history of cancer in me/ history of cancer in the family. <input type="checkbox"/>
5	Have a history of genetic disease in the immediate family or close relatives. <input type="checkbox"/>
6	I want to know the future risks and possibilities regarding my health. <input type="checkbox"/>
7	I want to check if we are carriers for any genetic illness. <input type="checkbox"/>
8	I want to know treatment plans based on genetics for our illness. <input type="checkbox"/>
9	I have received an abnormal prenatal screening test or Amniocentesis. <input type="checkbox"/>
10	I want to do it because my other family members have taken genetic testing. <input type="checkbox"/>
11	I want to know my Genetic makeup. <input type="checkbox"/>

## Past Medical History NIL.

Asthma	<input type="checkbox"/>	Peptic Ulcer disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Cerebrovascular Accidents/ Stroke	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Myocardial Infarction/ Heart Attack	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Frequent Sinus Infections	<input type="checkbox"/>	Psoriasis/Skin Conditions	<input type="checkbox"/>
Others	<input type="checkbox"/>		

## Past Surgical History NIL

Appendectomy	<input type="checkbox"/>	Joint Replacements	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	Cardiac Stent Placements	<input type="checkbox"/>
Coronary Artery Bypass Grafting (CABG)	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>
Splenectomy	<input type="checkbox"/>	Oophorectomy	<input type="checkbox"/>
Bariatric Surgery	<input type="checkbox"/>	Cholecystectomy	<input type="checkbox"/>
Others	<input type="checkbox"/>		

## Family History

Condition		If Yes, which member of the Family							
Allergies	<input checked="" type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Asthma	<input checked="" type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Depression/Suicide Attempts	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Premature Myocardial Infarction	<input checked="" type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input checked="" type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input checked="" type="checkbox"/>
Sudden Death	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input checked="" type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Consanguineous Marriage	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				
Cerebrovascular Accident	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	Father	<input checked="" type="checkbox"/>	Mother	<input checked="" type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Hearing/Speech Problems	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Alcohol Abuse	<input checked="" type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input checked="" type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Liver Cirrhosis	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Connective Tissue Diseases	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Others	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>

p. grand  
mother  
+ aunt

Maternal  
Uncles

## Mental Health History (Subjective)

Do you face any difficulty concentrating on your work?	Yes <input type="checkbox"/>	Sometimes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Have you lost much sleep/difficulty sleeping?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do you feel you are not playing a useful part in your work?	Yes <input type="checkbox"/>	Sometimes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are under constant stress?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do you feel you could not overcome difficulties?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do you feel unhappy or depressed most days of the week?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do you feel you are losing confidence?	Yes <input type="checkbox"/>	Sometimes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Do you have any stressors in family or professional life more than ordinary?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do you consider yourself an anxious person?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Details if Yes for any question above			

## Sexual History

Women		
Menstrual Cycles	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/>
History of Infertility	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Men		
Erectile Dysfunction	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## Current and Past Medications

Please name the list of Medications being used currently

	Name of the Medicine	Dose	Frequency
1	Aspirin		
2			
3			
4			

## Review of Systems

Constitutional		ENT	
Lack of Energy	<input type="checkbox"/>	Sinus Problem	<input type="checkbox"/>
Unexplained Weight Loss/Gain	<input type="checkbox"/>	Difficulty in Hearing	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Respiratory	
Night Sweats	<input type="checkbox"/>	Shortness Of Breath	<input type="checkbox"/>
Cardiovascular		Prolonged Cough	<input type="checkbox"/>
Heart Racing/Palpitations	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Gastrointestinal	
Swelling of legs/feet	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>
Pain in calf while walking	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
GU		Intolerance to certain food	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	Diarrhea/ Loose Stools	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	Musculoskeletal	
Kidney Stones	<input type="checkbox"/>	Joint Pains	<input type="checkbox"/>
		Aching Muscles	<input type="checkbox"/>
		Swelling of Joints	<input type="checkbox"/>
		Back pain	<input type="checkbox"/>

<b>Skin</b>	
Itching	<input type="checkbox"/>
Persistent Rash	<input type="checkbox"/>
New Skin Lesions	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>
Excessive Hair	<input type="checkbox"/>
<b>Neurologic</b>	
Frequent Headaches	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
Change in Sensation	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Tremors	<input type="checkbox"/>
Episodes of Vision Loss	<input type="checkbox"/>
<b>Endocrine</b>	
Intolerance to Heat or Cold	<input type="checkbox"/>
Frequent Hunger or Thirst	<input type="checkbox"/>
Changes in Sex Drive	<input type="checkbox"/>
<b>Allergic/Immunologic</b>	
Food Allergies	<input type="checkbox"/>
Seasonal Allergies	<input checked="" type="checkbox"/> <i>winter</i>
Itching Eyes/ Sneezing	<input type="checkbox"/>
Frequent Infections	<input checked="" type="checkbox"/> <i>Dust Allergy</i>

## Personal History/Health

Do You Drink Alcohol?	Yes <input checked="" type="checkbox"/>	Previous Drinker <input type="checkbox"/>	Never <input type="checkbox"/>	
How Many Drinks Per Week?	Occasionally 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	More Than 3 <input type="checkbox"/>
Do You Smoke Cigarettes	Yes <input type="checkbox"/>	Previous Smoker <input type="checkbox"/>	Never Smoker <input checked="" type="checkbox"/>	
If Yes, How Many Packets of Cigarettes Per Day?	Less than 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
What is your wake up time	Before 6 am <input type="checkbox"/>	After 6 am <input checked="" type="checkbox"/>		
What is your go to bed time	Before 8 pm <input type="checkbox"/>	After 8 pm <input checked="" type="checkbox"/>		
Do You Workout	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>		
If Yes, How Many Times Per Week?	Less than 4 <input type="checkbox"/>	More than 4 <input type="checkbox"/>		
Any participation in active sport when young?	Yes <input type="checkbox"/>	Never <input type="checkbox"/>		

Diet Non-Veg.

How many meals/day	Less than 3 <input type="checkbox"/>	3 <input type="checkbox"/>	More than 3 <input checked="" type="checkbox"/>	Snacking. <i>(Handwritten)</i>
How many times do you eat processed foods per week(Chips,Fried Items, Fast Food)?	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you eat outside food?	None <input type="checkbox"/>	1 <input checked="" type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you have soft/carbonated drinks per week?	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
	<i>Rarely.</i>			

## Physical Examination

- a. Blood Pressure: \_\_\_\_\_
- b. Pulse Rate: \_\_\_\_\_
- c. Height: \_\_\_\_\_
- d. Weight: \_\_\_\_\_
- e. BMI: \_\_\_\_\_

## Blood Work

Mandatory Tests	
1	Complete Blood Count <input type="checkbox"/>
2	Thyroid Profile <input type="checkbox"/>
3	HbA1C <input type="checkbox"/>
4	Liver Function Test <input type="checkbox"/>
5	Kidney Function Test <input type="checkbox"/>
6	Lipid Profile <input type="checkbox"/>

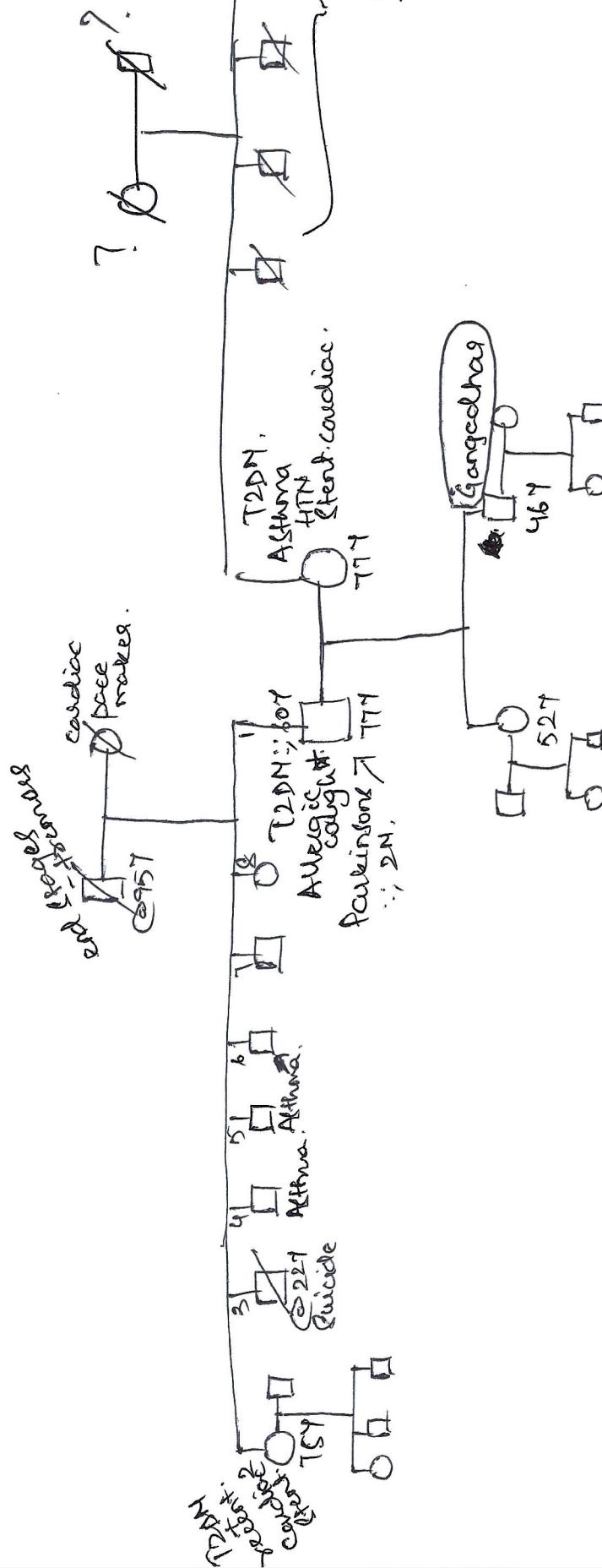


PATTERNS

- \* Dizziness (since 1.5<sup>Y</sup>)
  - hand tremors
  - slow walking. } see
  - slow speech. }
  - Muscle weakness
  - Confusion

Slow walking. } Recently.  
Slow speech. }  
Mild weakness generalized.  
Convulsions

**PROFESSION:** QC Lab assistant -  
 exposure to chronic cold tire.  
  
**Smoking history:** -ve.  
**Asthma:** -ve. (in past once flares)



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$$23 + 23 = 46$$

$$\frac{44 -}{+ 2 -} \text{ex.}$$

Mother

X

Father

X

Alphabet

X

Off: 28/11/24

### PATIENT CONSENT FORM

**KHGUBS 770**

**46M**

**DATE: 06 Jan 2023**

I, GANGADHAR (Patient's name) aged 46 Gender M (herein afterreferred to as "I" or "Me"), hereby authorize K&H Personalized Medicine Clinic Private Limited (hereinafter referred to as the "Clinic") to conduct genomics tests and analysis (hereinafter referred to as "Sevices/Test"). I hereby agree to submit the sample for testing as recommended by my physician/medical practitioner. I understand that the samples will be collected by a qualified lab technician using medically accepted techniques, the risk(s) of which have been explained by my medical practitioner and are acceptable to me.

By signing this declaration of consent, I acknowledge that I have read and understood all the terms stated herein below:

1. The medical practitioner/ physician has fully and clearly explained the risks, outcomes, benefits and limitations of the genomics testing. I hereby agree that I have had an opportunity to discuss and clarify the risks and other concerns with the medical practitioner. I hereby give my free consent to the Clinic to conduct the Test on the sample provided by me.
2. I shall provide accurate medical and personal information about my age, medical history, health concerns, symptoms, dietary habits, allergies, medications, lifestyle habits, family history and/or any other details /questions that enables the Clinic to conduct and interpret the results of the tests effectively. I, therefore, confirm and declare that all the information and materials provided by me are true, accurate and complete to the best of my knowledge.
3. I, shall not hold the Clinic responsible or liable for the interpretation or analysis of the tests conducted by the Clinic solely based on the medical information provided by me.
4. I understand that though genomics testing provide generally accurate results, several sources of errors are possible including but not limited to the possibility of a failure or error in sample analysis, as with the case of any genomics tests. I understand that genomics tests are relatively new and are being improved and expanded continuously. Hence, due to current limitations in technology and incomplete knowledge and information on genes and diseases, there is a possibility that the test results may be inconclusive, uninterpretable or of unknown significance which may require further testing.

5. I hereby understand that the results/outcome of the tests conducted by the Clinic is indicative and cannot be perceived as conclusive or guaranteed. I also understand that the Test reports may provide information not anticipated and unrelated to my reported clinical symptoms, but can be of medical value for patient care. I understand that the results of my tests are not be readin isolation and further clinical correlation may be required.
6. I understand that the Clinic is not a specimen banking facility and therefore the sample shall be discarded after 2(two) months and shall not be available for future clinical tests.
7. I understand that the report and any record of my personal data including but not limited to my name, age, address, symptoms, descriptions, Test reports etc. in the possession of the Clinic is in safe custody and in an encrypted form and I hereby provide my consent to the Clinic to store my personal data and information for medical research purpose.
8. I further consent and authorize to the collection, processing, use, storage and retention of the anonymized data, the sample collected and related anonymized reports from the tests conducted for ongoing test developments, educational, scientific research and/or other related activities. I understand that the Clinic has taken the appropriate measures to maintain confidentiality. I hereby understand that this is purely for the purpose mentioned hereinbefore and my identity shall not be revealed in any manner whatsoever.
9. I understand that the clinic shall not disclose or hand-over the results of the tests to anyone else other than me, unless until required by law or expressly authorized by me.
10. I herein agree that a copy of this consent form is retained by me for any future use that may arise.



Signature of the Patient/ Attendee