REQUEST FORM

UNIT PROTEIN KHAS (UPK),
SPECIALIZED DIAGNOSTIC CENTRE (SDC)
INSTITUTE FOR MEDICAL RESEARCH (IMR)
NATIONAL INSTITUTES OF HEALTH, MOH
Jalan Pahang, 50588 Kuala Lumpur, Malaysia
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IMR Lab. Number

IMPORTANT NOTICE : To ensure correct, reliable result and interpretation given, the following must be followed :

1. ***Please fill up the entire form.***
2. ***All samples (plasma / urine / CSF) must be frozen for transport and transport in DRY ICE to IMR.***

Name : _____ **Age :** _____ **Sex :** M / F / U **Race** : M / C / I / O

RN : _____ **ID :** *(preferably patient's IC)* _____ **Hospital :** _____ **Ward :** _____

Address : _____ **Tel :** _____

1. Symptoms / Signs of Current Illness :

Fever		Poor sucking / feeding	
Pallor		Respiratory problem	
Jaundice		Difficulty in breathing	
Hypothermia		Mental retardation	
Hypotonia / floppy		Developmental delay	
Cyanosed		Failure to thrive	
Lethargy		Feeding intolerance	
Easily irritable		Septicaemic-like illness	
Seizures or h/o seizures		Headache	
Drowsy		Smelly urine	
Coma		Colored urine	
Abnormal behaviour		Skin lesions	
Frequent vomiting		Eye lesions	

Other symptoms / signs :
_____
_____
_____

2. Feeding History :

Type of milk : Breast / Formula / Mixed /
Solid diet : _____

3. Family History : Consanguinity : Yes / No. If Yes please specify : _____

Occurrence of / in	Stillbirth	Neonatal death	Neonatal seizures	Metabolic disease
Siblings				
Maternal side				
Paternal side				

4. Physical Examination :

Respiratory distress		Hyperreflexia	
Dysmorphic features		Nystagmus	
Hypothermia		Optical atrophy	
Cardiomyopathy		Ptosis	
Drowsy		Abnormal odour	
Coma		Abnormal hair	
Opisthotonus		Hepatomegaly	
Dystonia		Splenomegaly	
Choreoathetoid movement		Eczema / Other rashes	
Hypotonia		Others (specify)	

5. Treatment Given : (specimen should be taken before any form of treatment given or stop for 2-3 days)

Drug therapy :
Antibiotic : No / Yes _____
Steroid : No / Yes _____
Anticonvulsant : No / Yes _____
Other drug : (please state) _____
Fluid infusion : Saline / Dextrose / Mannitol / Parenteral feeding / Others : _____

6. Lab Result : (before treatment is given)

LFT
ALT : _____ U/L
AST : _____ U/L
ALP : _____ U/L

Blood Glucose : _____ mmol/L
Blood Ammonia : _____ umol/L
Blood Lactate : _____ mmol/L
Pyruvate : _____ mmol/L

Urine Analysis
pH : _____
Ketones : Pos / Neg
Reducing Sugar : Pos / Neg

Blood Gases : Normal / Met acidosis / Met alkalosis / Resp acidosis / Resp alkalosis

Anion Gap : _____

CT Scan / MRI : _____
Other relevant test (specify) :

Provisional Diagnosis :

7. Test Required : (Please tick ONLY appropriate test / s required)

1		Amino Acids, Plasma
2		Amino Acids, CSF
3		Pipecolic Acid, Plasma
4		S-Sulphocysteine, Urine
5		Delta-Amino Levulinic Acids (Delta-ALA), Urine *(protect from light)*
6		Transferrin Isoform, Serum

BY CONSULTATION ONLY
(Please state the person's name whom spoken to upon requesting the following test / s)

SPOKEN TO :

7		Amino Acids, Urine
8		Others (please specify)

Guidelines for sample collection:

1. Serum/Plasma

a) At least ***3mL of serum / plasma*** in plain tube are required.

b) Serum / plasma condition ***must be clear*** and ***not hemolysed, turbic or lipaemic.***

c) Refrigerate serum / plasma immediately after collection.

2. Urine

a) At least ***5mL of urine*** in sterile container are required.

b) Refrigerate urine immediately after collection.

3. CSF

a) At least ***200µL of CSF*** in bijou bottle or sterile container are required.

b) Freeze CSF immediately after collection.

****For details information of sample requirements , please refer to IMR Test List and IMR Handbook available at IMR Website (www.imr.gov.my)***

Collected by	:	
Date specimen collected	:	
Date specimen sent	:	
Specialist In-Charge (Sign & Stamp)	:	