



For Endocrine IMR use only:

Endocrine IMR Lab Number

Please stamp DATE of request  
 and state the SAMPLE  
 CONDITION upon receiving at  
 ENDOCRINE IMR Laboratory

HOSPITAL/ CLINIC/ LAB: \_\_\_\_\_

A. Patient details	
1. Name:	2. R/N:
3. I/C No.: (Please use Mother's IC if newborn)	4. Date of birth:
5. Age:	6. Race: <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (please specify) _____
7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	8. Ward/ Clinic:

**B. Relevant clinical information and physical examination: (Please tick Yes/ No and if Yes, please specify )**

1. Signs & symptoms:		
2. Family history:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Please specify : -----
3. Treatment given/ Drug therapy:		Please specify :
• Steroids:	Yes <input type="checkbox"/> No <input type="checkbox"/>	-----
• Hormonal treatment:	Yes <input type="checkbox"/> No <input type="checkbox"/>	-----
• Anti-reproductive therapy:	Yes <input type="checkbox"/> No <input type="checkbox"/>	-----
• Oral hypoglycemic agents / Insulin:	Yes <input type="checkbox"/> No <input type="checkbox"/>	-----
• Other drugs :( Please state )	Yes <input type="checkbox"/> No <input type="checkbox"/>	-----

**C. Laboratory results:**

Basal Cortisol : .....	Blood glucose : .....
LH : .....	HbA1c: .....
FSH : .....	Blood lactate : .....
Progesterone : .....	Renal profile : Sodium : ..... Potassium: .....Urea: ..... Creat : .....
Testosterone : .....	Liver profile : ALT : .....AST : ..... ALP : .....
Urine glucose: _____	Urine Ketones: _____
	Urine Proteins: _____
Blood Gases:	Normal / Metabolic acidosis/ Metabolic alkalosis/ Respiratory acidosis/ Respiratory alkalosis
	Anion gap: _____

**Provocative tests** (Please include full results and interpretation)

Synacthen test:

β HcG Stimulation test:

Other tests:

**Ultrasound / CT scan /MRI findings:**

Other relevant tests ( specify ) :

**D. Provisional Diagnosis :**

**E. Test requested : ( Please tick ONLY appropriate test/s required )**

17-Hydroxyprogesterone (random)

17-Hydroxyprogesterone (0, 30, 60 min)  
For Synacthen: please include 0, 30, 60 min samples in a single request form

Anti-Müllerian Hormone ( AMH)

**Diabetes Antibodies Panel :** Please send in a single request form & single tube

Anti-Islet Cells (ICA ) , Anti-Glutamic Acid Decarboxylase (GAD 65) , Anti-Insulinoma-Associated Antigen 2 (IA2)

Anti-Glutamic Acid Decarboxylase (GAD 65)  
(For neurological disorders )

Other relevant tests ( specify ) : \_\_\_\_\_

**IMPORTANT NOTICE:**

To ensure correct and reliable result given, the following must be followed strictly :

1. Please fill up the entire form with clinician requestor signature.
2. Separate plasma/ serum from RBC immediately.
3. Grossly hemolysed samples will be rejected. Please send only separated serum/ plasma (not the whole blood/ separated sample in gel tube).
4. At least 1.0 – 2.5 ml of serum/ plasma in plain tube is required for each test (Please send one tube with sufficient volume if request for multiple tests).
5. All samples must be kept and transported in suitable temperature, 2-8 °C to IMR.

\*\*\*\*\* For detailed information of sample requirement, please refer to IMR test list available at IMR website ([www.imr.gov.my](http://www.imr.gov.my)).

Collected by:

Date of specimen collection:

Date of specimen sent:

Requested by:

Specialist in charge Signature & stamp: