Appendix: 4

Case record form

GENETICS AND BIRTH DEFECTS CLINIC
DEPARTMENT OF PEDIATRICS
MAULANA AZAD MEDICAL COLLEGE,
LOK NAYAK HOSPITAL, NEW DELHI-110002

A Typical Request Form for Screening of Inborn Metabolic Disorders

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>OP/IP No</th>
<th>Sex</th>
<th>Ward</th>
<th>Unit</th>
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Lab No. (Lab purpose): 

Please tick the relevant

A. Presenting Complaints:

i. Developmental delay

ii. Regression of previously learned skills (specify)

iii. Seizures

iv. Vomitting

v. Others if any

B. Past History:

i. Motor milestones
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ii. Mental milestones

iii. Convulsions

iv. Abnormal color/odour of urine

C. General Examination:

i. Facial features

ii. Liver

iii. Spleen

iv. Corneal clouding/cherry red spot/
dislocated lens/any other (specify)

v. Any other finding (specify)

D. Neuropsychiatric examination (In brief)

i. Levels of consciousness

ii. Behavioural abnormality if any (specify)

iii. Speech

iv. Vision

v. Fundus

vi. Motor system

E. Family History:

i. Consanguinity

ii. Pedegree :

F. Lab investigations done (if any)

 & findings
G. Present medications (if any)  

(Specify)

H. Investigation(s) required

(Specify)

**Nature of the specimen sent:** Urine@/blood/CSF/Amniotic fluid*/biopsy*  
(Circle the appropriate)  
(@: Random/24 hrs:* :  
Confirm with the lab before collecting the specimens)

**Time of Collection:**

Time:  
Date: 

**Date and Time of specimen received at lab:**

Date:  
Time: 

**Signature**

**Name:**