Micro Health Laboratories
.....for precious life

Test Request Form
International V-0.4

MICRO GEN™ **HAIR PGx** *Pharmacogenetic analysis*

*accurate information is necessary for a valid interpretation | please (✓) boxes

PATIENT INFORMATION GENERAL*

Name

Date of Birth | Sex | ☐ Male ☐ Female

Nationality | QID

MRN / File No. | Ph No.

REFERRED BY*

Doctor / Hospital / Clinic / Lab - Account Code

Mail Id.

Ph No. | Seal / Signature

TEST REQUESTED

✓ **HAIR PGx** - Pharmacogenetic Analysis

HAIR PGx *Pharmacogenetic analysis* — Buccal Swab

Height (cm) _____

Weight (kg) _____

✓ **HAIR** Element Analysis - **BASIC**

HAIR Basic **Toxic & Essential** *Element analysis* — 20 Mg Hair

✓ **HAIR** Element Analysis - **PREMIUM**

HAIR Premium **Toxic & Essential** *Element analysis* — 20 Mg Hair

NATURAL HAIR COLOUR : _____ **OCCUPATION :** _____

ANY PRESENT MEDICATION / MEDICAL CONDITION : _____

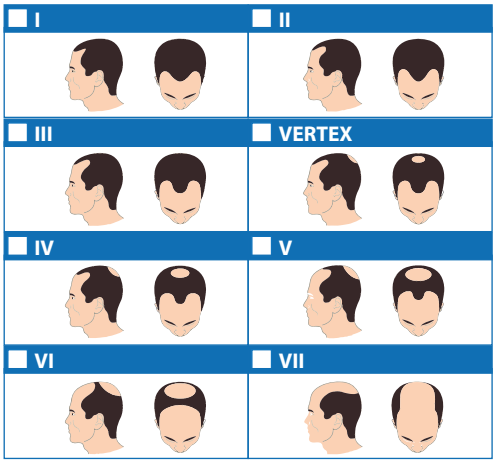
ANY SHAMPOO / CONDITIONER / DYES USED : _____

QUESTIONNAIRE FOR HAIR PGx TEST — MALE & FEMALE

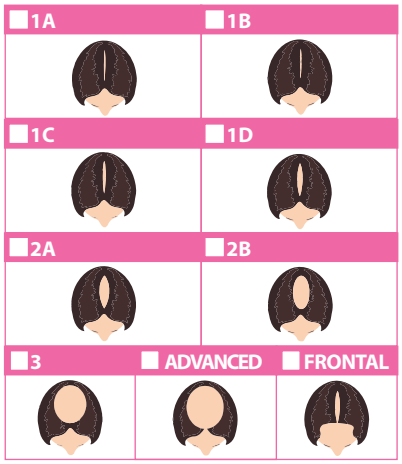
FAMILY AND DISEASE DATA

Mandatory requirements for the service order HAIR PGx:
1. Complete the Test Requisition Form (TRF) & the Questionnaire for test ordered.
2. Ensure, The patient's consent signature is mandatory for DNA sample processing.

GRADE MALE



GRADE FEMALE



TYPE OF ALOPECIA
- ☐ Androgenic alopecia
- ☐ Telogen Effluvium (seasonal)
- ☐ Alopecia areata

DIRECT FAMILY MEMBERS SUFFERING FROM ALOPECIA AND / OR HAIR LOSS
- ☐ None
- ☐ Parents
- ☐ Siblings
- ☐ Both

FOR HOW LONG HAS YOUR HAIR BEEN FALLING OUT?
- ☐ More than a year
- ☐ Less than a year
- ☐ My hair doesn't fall out

DO YOU HAVE HYPERSENSITIVITY TO CAFFEINE?
- ☐ Yes
- ☐ No

HYPERSENSITIVITY
- ☐ Minoxidil
- ☐ Latanoprost
- ☐ Prostaquinon
- ☐ Cetirizine
- ☐ 17-α Estradiol
- ☐ Finasteride
- ☐ Dutasteride
- ☐ Cyproterone
- ☐ Spironolactone
- ☐ Tretinoin

DO YOU CONSUME ANY OF THE FOLLOWING SUBSTANCES?
- ☐ Alcohol
- ☐ Tobacco
- ☐ Cannabis
- ☐ Cocaine
- ☐ LSD
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Amphetamines

DO YOU HAVE ANY OF THE FOLLOWING DISEASES?
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes
- ☐ Cushing Syndrome
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Endometriosis
- ☐ Hypertension
- ☐ Hirsutism
- ☐ Anemia
- ☐ Autoimmune diseases
- ☐ Cáncer
- ☐ Benign prostatic hyperplasia
- ☐ SAHA (Seborrhoea, Acne, Hirsutism & Alopecia)
- ☐ Cardiovascular diseases
- ☐ Hypotension
- ☐ Oestrogenic hormonal imbalance

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS?
- ☐ Anti-acne
- ☐ Antidepressants
- ☐ Antihypertensive
- ☐ Contraceptives
- ☐ Corticoids
- ☐ Estrogen synthesis - inhibitors
- ☐ SADBE

DO YOU HAVE ANY OF THESE ALLERGIES OR SENSTIVITIES?
- ☐ Pollen
- ☐ Mites
- ☐ Fungi
- ☐ Animal hair
- ☐ Insect bite
- ☐ NSAID
- ☐ Antibiotic
- ☐ Insulin
- ☐ Propylene glycol alcohol
- ☐ Penicillin

ARE YOU CURRENTLY FOLLOWING A HYPOCALORIC DIET?
- ☐ Yes
- ☐ No

DO YOU TAKE TESTOSTERONE (ANABOLIC) DERIVATIVES?
- ☐ Yes
- ☐ No

DO YOU HAVE ANY OF THESE EATING DISORDERS?
- ☐ Bulimia
- ☐ Anorexia
- ☐ Vigorexia

ARE YOU PREGNANT?
- ☐ Yes
- ☐ No

Micro Health Laboratories
.....for precious life

Test Request Form
International V-0.4

MICROGEN™

HAIR PGx
Pharmacogenetic analysis

*accurate information is necessary for a valid interpretation | please (✓) boxes

QUESTIONNAIRE FOR HAIR PGx TEST - MALE & FEMALE

DATA RELATED TO YOUR ENVIRONMENT

DO YOU SUFFER STRESS?
- ☐ Yes
- ☐ No

HAVE YOU RECENTLY CHANGED YOUR RESIDENCE?
- ☐ Yes
- ☐ No

DO HAVE IRREGULAR MENSTURATIONS?
- ☐ Yes
- ☐ No

DO YOU SUFFER FROM DEPRESSION?
- ☐ Yes
- ☐ No

DO YOU GET ENOUGH REST?
- ☐ Yes
- ☐ No

DO HAVE A HEAVY MENSTURAL CYCLE?
- ☐ Yes
- ☐ No

IS YOUR WORK IN CONTACT WITH TOXIC / POLLUTING MATERIALS?
- ☐ Yes
- ☐ No

DO YOU RECENTLY HAD A CHILD?
- ☐ Yes
- ☐ No

DO HAVE POST-SURGICAL STRESS?
- ☐ Yes
- ☐ No

DATA RELATED TO YOUR ENVIRONMENT

CHOLESTEROL LEVEL?
- ☐ High
- ☐ Normal
- ☐ Low

LEVEL OF HEMOGLOBIN?
- ☐ High
- ☐ Normal
- ☐ Low

LEVEL OF HEMATOCRIT?
- ☐ High
- ☐ Normal
- ☐ Low

TSH
- ☐ High
- ☐ Normal
- ☐ Low

T3
- ☐ High
- ☐ Normal
- ☐ Low

T4 (THYROID) LEVELS?
- ☐ High
- ☐ Normal
- ☐ Low

SIZE OF RED BLOOD CELLS?
- ☐ High
- ☐ Normal
- ☐ Low

DO YOU USE ANY OF THESE HAIR PRODUCTS?
- ☐ Hair spray
- ☐ Gummies
- ☐ Hair gel
- ☐ Hair dryer
- ☐ Hair dyes
- ☐ Baseball cap
- ☐ Hair straightener

CLINICAL INSPECTION

HAIR LENGTH
- ☐ Short
- ☐ Mid length
- ☐ Long

HOW MUCH HAIR FALLS OUT?
- ☐ A lot
- ☐ Little bit
- ☐ Nothing

LAST TIME YOU WASHED YOUR HAIR
- ☐ Less than 24 hours ago
- ☐ More than 24 hours ago

DO YOU HAVE ALOPECIC PLAQUES?
- ☐ Yes
- ☐ No

ALOPECIA IS NOTICEABLE ON YOUR:
- ☐ Eyebrows
- ☐ Beard
- ☐ Eyelashes

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS ON THE SCALP?
- ☐ Seborrhea
- ☐ Scales
- ☐ Scabs
- ☐ Irritations
- ☐ Psoriasis
- ☐ Seborrheic dermatitis
- ☐ Dandruff
- ☐ Dermatitis

Are you using any treatment or supplement for alopecia at the moment? Please indicate which

And in the past? Indicate which

PULL TEST
- ☐ Unknown
- ☐ Positive
- ☐ Negative

HOW DOES HAIR LOOK?
- ☐ Very bad
- ☐ Good
- ☐ Normal
- ☐ Bad
- ☐ Very Good

PATIENT CONSENT AND AUTHORIZATION FORM

By signing this form, you (the patient or legal guardian) consent to MHL- Micro Precision Dx performing the requested genetic test and agree to the following:

1. MHL- Micro Precision Dx conducts genetic tests upon the request of a licensed physician.
2. Sample and Medical Data: A biological sample and relevant medical history are required. MHL- Micro Precision Dx will use these solely for the requested test.
3. Data Use: You authorize MHL- Micro Precision Dx to collect and use the patient's medical data for generating the genetic report and sharing it with the requesting physician.
4. Confidentiality: Patient data and samples are confidential and will not be accessed by unauthorized individuals.
5. Data Processing: By signing, you consent to the processing of personal data for the test. Data will be stored as required by law and not shared unless legally obligated.
6. Patient Rights: You may revoke consent or request access, correction, or deletion of your data by contacting info.pdx@microhealthcare.com.

Patient or Parent/Guardian Signature: _____

By signing in this TRF, you confirm your informed consent for the test and data processing.

Requesting Physician Signature: _____

Date & Place : ☐☐☐ _____

FOR LABORATORY USE ONLY

TRIAGE REMARKS

TRANSPORT TEMPERATURE
- ☐ Ambient Temperature
- ☐ Refrigerated (2° to 8°C)
- ☐ Frozen (-20°C)

SAMPLE COLLECTED / RECEIVED @ LAB
Date ☐☐☐
Time ☐☐ am / pm

ACKNOWLEDGEMENT

SAMPLE RECEIVED / VALIDATED BY

Technician Name / Signature

INDIA | QATAR | DUBAI | GHANA | BANGLADESH

helpdesk@microhealthcare.com
www.microhealthcare.com