Request Form B

Date（month / day / year)
_____/_____/_____

Patient information

Last name　　First and middle names

_____　_____M._____

Date of birth　　Date of urine sampling　　sex : ☐ Male ☐ Female

_____/_____/_____　_____/_____/_____

Any medication (including infusion) used for 1-2 days before urine sampling

_____

_____

_____

_____

☐ glycerol, ☐ mannitol, ☐ glucose infusion, ☐ MCT milk, ☐ special diet : _____

_____

Symptoms etc.

☐ Vomiting　☐ Epilepsy　☐ Covulsions　☐ Kidney stone (☐ yes　☐ no)
☐ Abnormal uric acid level (☐ yes ☐ no.　If yes, ☐ high　☐ low)

Major complaint

_____

_____

_____

_____

_____

Applicant (responsible person) information

Title (Dr / Prof / Mr / Ms) :　　☐ **have paid**

Last name　　First and middle names

_____　_____M._____

Signature　　e-mail address

_____　_____

Address _____

_____

_____

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