MOLQ™ LABORATORY

TEST REQUISTION FORM

Patient Details

First Name : Mr. MAN Last Name : SINGH

Age : 19y/m Gender : Male ☑ Female ☐

Address :

Contact No. : 8059565189

E-mail ID

Referred by Contact No. :

For Maternal Screening - Date of Birth :- D D M M Y Y Y Y

Weight : kg. Height : ft inches, LMP Last Ultrasound Report

Billing Information

Client Name : Civil Hospital (M)

Client ID :

Total Amount : 1210/-

Amount Received : 1200/- Receipt No. :

Amount Balance / Due : 10/-

Payment via : ☐ CASH ☐ CHEQUE ☐ CREDIT

Specimen Type Received (For MolQ use only)

☑ Serum	☐ Bone Marrow	☐ CSF
☐ Plasma: EDTA/FL/CIT	☐ FN Aspirate	☐ Fluid
☐ SST	☐ Tissue Formalin	☐ BAL
☑ W. Blood EDTA	☐ Paraffin Block	☐ Sputum
☐ W. Blood Fluoride	☐ Smear	☐ Urine
☐ W. Blood Heparin	☐ Slide (H&E)	☐ Stool
☐ W. Blood Sodium Citrate	☐ Pus	☐ Swab
	☐ Blood Culture Bottle	☐ Others

Other Sample Type / Source : 2

Received Specimen Information (For MolQ use only)

Temperature : ☐ Ambient ☐ Refrigerated ☐ Frozen

Date: Time :

Patient ID No. of vials/container

1	2

Signature of Accessioning Officer(s)

Test Name/Test Code

(Please refer to the Directory of Services for correct name and specimen type)

CM. BT- 1-39 Sec

AEC CT- 4-50 Sec

IgE Level

LFT

KFT

HBsAg

HIV

Instructions to Laboratory/Clinical Information

(P.T.O)

Sent Specimen Information

Temperature : ☐ Ambient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
E	MolQ 10204322
P	

Total No. of Vials/Container

Specimen Collection Information

Date: 28/12/17 Time :

Fasting : Yes ☐ No ☐ Fasting Period : Hrs.

Collection by : Rahul

Urine Volume : ml Hrs.

Patient Consent : I hereby authorize MoLQ Laboratory to use and share with affiliates my personal information including but not limited to any condition / disease information etc. as may be necessary to perform the test or services etc. Medical records/information, to the extent of the applicable by laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate research and in future research of any kind and at any time in the future. The samples will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of any publication by MoLQ Laboratory, patient's identity will remain confidential. I agree to this access of my medical records and specimen for diagnostic and research purpose.

Disclaimer : For any test/service related complain/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Dehradun, Uttrakhand. The financial liability or compensation of any sort is not more than MRP of the Test requested.

रोगी सहमति : मैं मोल्क्यु प्रयोगशाला को अधिकृत करता हूँ कि मेरी पूर्ण व्यक्तिगत जानकारी अपनी किसी भी शाखा के साथ साझा कर सकती है। मेरी बीमारी की हालत या सूचना का खुलासा अगर परीक्षण के संचालन के लिए आवश्यक है, तो मैं इसकी अनुमति देता हूँ यद्यपि यह जानकारी उस सीमा तक साझा की जाए जो कि कानूनी सीमा के अंतर्गत हो। मेरी इस प्रकार की जानकारी को पूर्ण रूप से गुप्त रखा जाए और सार्वजनिक रूप से उपलब्ध ना कराई जाए। इसके पश्चात मैं प्रयोगशाला को देबारा अधिकृत करता हूँ कि जो नमूना जाँच के लिए उपलब्ध करवाया था, उसमे से बचे हुए नमूने को प्रयोगशाला कभी भी और किसी भी समय किसी भी प्रकार के प्रयोग के लिए उपयोग में ला सकती है। शेष नमूने को पूर्ण रुप से अंकित किया जाए और गुप्त रुप से रखा जाए, जब इसको नष्ट किया जाए तो पूर्ण रुप से नियम और विनियमता का उपयोग किया जाए। किसी भी प्रकार के मोल्क्यु प्रयोगशाला के प्रकाशन में रोगी की निजी जानकारियों को पूर्ण रुप में गुप्त रखा जाएगा। मै सहमत हूँ कि मेरी मेडिकल रिकॉर्ड और मेरे बचे हुए नमूने को नैदानिक प्रयोग और किसी भी प्रकार के अनुसंधान के लिए उपयोग में लिया जा सकता है।

अस्वीकृति : किसी भी जाँच सम्बन्ध शिकायत या जानकारी हेतु आप मोल्क्यु प्रयोशाला को सम्पर्क कर सकते है, किसी भी प्रकार की कानूनी झगड़े हेतु हमारा मुख्यालय देहरादून, उत्तराखंड है, किसी भी जाँच का मूल्य उसके दिए अधिकत्तम फुटकर मूल्य से अधिक नहीं होगा।

Patient/Client /Doctor's Signature

Date : .....

Form QPCMOLQ2001c

MOLQ LABORATORY

Reference Laboratory
28-29, Sector 18 (P)
Gurgaon - 122015

INFORMED CONSENT FOR HIV TESTING

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.
I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: MANSINGH Date: 28/12/2017

Signature or Thumb impression: manSingh

Patient or person authorized to consent

Consent taken by Consulting Physician

Name: DR R.K SINGH Signature:

Indication: Date:

CAPEX Hospital & TRAUMA CENTRE