



TEST REQUISITION FORM

Patient Details

First Name: Mr Dhruv Last Name: Pratap Singh

Age: 31 M. Gender: Male Female

Address: CNH Hospital (EHL)

Contact No. : _____

E-mail ID _____

Referred by _____ Contact No. : _____

For Maternal Screening - Date of Birth :-

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

Billing Information

Client Name : _____

Client ID : _____

Total Amount : _____

Amount Received : _____ Receipt No. : _____

Amount Balance / Due : _____

Payment via : CASH CHEQUE CREDIT

Specimen Type Received (For MolQ use only)

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

Received Specimen Information (For MolQ use only)

Temperature : Ambient Refrigerated Frozen

Date: _____ Time : _____

Patient ID _____ No. of vials/container _____

1	2
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Signature of Accessioning Officer(s) _____

Test Name/Test Code

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

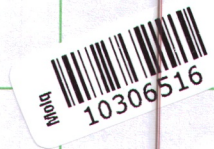
Tissue biopsy

Instructions to Laboratory/Clinical Information

Sent Specimen Information

Temperature : Ambient Refrigerated Frozen

Sample / Vial Type	Vial ID Barcode



Total No. of Vials/Container _____

Specimen Collection Information

Date: 20-1-18 Time : _____

Fasting : Yes No Fasting Period : _____ Hrs.

Collection by : Sharma

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, Uttarakhand. 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, उसमें 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 रूप से अंकित किया जाए और गुप्त रूप से रखा जाए, जब इसको नष्ट किया जाए तो पूर्ण रूप से नियम और विनियमता का उपयोग किया जाए। किसी भी प्रकार के मोल्क्यु प्रयोगशाला के प्रकाशन में रोगी की निजी जानकारियों को पूर्ण रूप में गुप्त रखा जाएगा। मैं 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 प्रयोगशाला को सम्पर्क कर सकते हैं। किसी भी प्रकार की कानूनी झगड़े हेतु हमारा मुख्यालय देहरादून, उत्तराखण्ड है, किसी भी जाँच का मूल्य उसके दिए अधिकतम फुटकर मूल्य से अधिक नहीं होगा।

Patient/Client /Doctor's Signature
Date : _____

HISTOPATHOLOGY REQUISITION FORM

Name of Patient Mr. Dhruv Pantap Singh Date of Birth/ Age 31 y/m
 Sex: Male, Female Lab Reference No.

Accession No. (For Lab use only) _____

Client Code: UHID 24328 Date & Time of Sample collection _____

Telephone _____ Referring Doctor (Name & Tel No.) Dr. Avaneesh Hariza (9958368882)

Site of Specimen : Lump abdominal wall

Relevant Clinical History : Lump abdominal wall

Additional Clinical and Relevant Data : _____

(Previous Biopsy / FNAC / X-ray etc.) : _____

Clinical Diagnosis

Type of Specimen

- Large Medium Small IHC markers Special Stains

Histopath Slides / Block for review

Fixation

No. of slides _____

Adequate

No. of Blocks _____

Inadequate

INSTRUCTION FOR FILLING UP FORM:

1. Please tick appropriate boxes only
2. Please furnish complete clinical detail along with Request form.
3. Do not omit telephone number of Patient / Referring Doctor.
4. Guidelines for Creating Formalin - All the samples should be in 10% formalin (can be made by mixing 1 part formalin (40% formaldehyde solution) with 9 part water.
5. Volume of fixative should be atleast 10 times the volume of tissue.

<input type="checkbox"/>	HI001	HISTOPATHOLOGY, BIOPSY, SMALL SPECIMEN: <input type="checkbox"/> Endometrium <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> Endoscopic biopsies <input type="checkbox"/> Trucut biopsy <input type="checkbox"/> <input type="checkbox"/> Appendix <input type="checkbox"/> Fallopian Tubes <input type="checkbox"/> Conjunctival Biopsy <input type="checkbox"/> Small diagnostic / Incision biopsies <input type="checkbox"/> Skin Biopsy <input type="checkbox"/> Fistula In Ano
<input type="checkbox"/>	HI002	HISTOPATHOLOGY, BIOPSY, MEDIUM SPECIMEN: <input type="checkbox"/> Breast lump <input type="checkbox"/> Lymph Node <input type="checkbox"/> Hysterectomy (Uterus with Cervix) <input type="checkbox"/> Ovarian Cyst <input type="checkbox"/> Gall bladder <input type="checkbox"/> Prostate [(TURP) / Enucleation] <input type="checkbox"/> Superficial lumps <input type="checkbox"/> Brain & Spinal cord tumors <input type="checkbox"/> Small excision Biopsies <input type="checkbox"/> Ovarian Cyst <input type="checkbox"/> Eye Ball (non-tumorous) <input type="checkbox"/> <input type="checkbox"/> Placenta <input type="checkbox"/> Thyroid Gland <input type="checkbox"/> Fibroids (Enucleated) <input type="checkbox"/> Products of conception <input type="checkbox"/> <input type="checkbox"/> Bladder(TURBT) <input type="checkbox"/> Small bone biopsy < 1 cm
<input type="checkbox"/>	HI003	HISTOPATHOLOGY, BIOPSY / ALL CANCER RESECTION LARGE SPECIMENS: <input type="checkbox"/> Esophagectomy <input type="checkbox"/> Gastrectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Heml / Total colectomy <input type="checkbox"/> Large Bone Resection <input type="checkbox"/> Ovarian Tumor Resection <input type="checkbox"/> Radical Nephrectomy for Cancer <input type="checkbox"/> Radical Neck Dissection <input type="checkbox"/> Radical Hysterectomy for tumours <input type="checkbox"/> Radical Orchiectomy for Cancer <input type="checkbox"/> Soft Tissue Tumor Resections <input type="checkbox"/> Head & Neck Resection <input type="checkbox"/> Radical Cholecystectomy <input type="checkbox"/> Bone <input type="checkbox"/> Uterus with Cervix and Ovaries



IP No: 18/692 UHID : 24326
Mr. Dhruv Pratap Singh
31 Yrs/Male NURSING STATION-1/106
Dr. Avaneesh Hasiza ;ADMIN

Operation Notes

Patient's Name Mr. Dhruv Pratap Singh Age 31 Sex M

UHID 24326 I.P. No. 18/692

Consultant Dr. Avaneesh Hasiza

Bed No./Room No./DCU No. _____

Date of Admission 20/1/18

Diagnosis Lump abdominal wall

Operation Performed Excision lump + biopsy + flap closure

Date and Time 20/1/18

Surgeon Dr. Avaneesh Hasiza Asst. Navleen

Anaesthetist Dr. Y. R. Kapoor Scrub Sister _____ Sponge Count Sister _____

Implants _____

Soft tissue lump ant. abdominal wall
of around 3x2 cm., irregular, hard,
elliptical incision made
Details lump excised

- Haemostasis ensured.
- Primary flaps sutured.
- Flap closure done.
- ASD done.

Post op orders:
N.P.O. for 2 hrs., Then liquid diet
INF - DNS @/RL @
Inf. Monocel - 1g 1/w stat (AST)

Tissue sent for Histopathology