Duplicate *

Date	20/01/2018	Srl No.	6	Patient Id	1801206
Name	Mrs. JYOTI KANYAL	Age	30 Yrs.	Sex	F
Ref. By	Dr. POOJA MEHTA				

USG SPECIAL

USG LOWER ABD + NT

USG OBSTETRICS:-

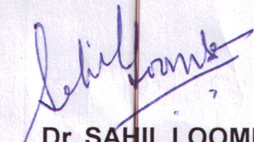
LMP:26/10/2017 GA by LMP:12 wks 2 day EDD by LMP:02/08/2018

Maternal:
UTERUS is gravid with a normal appearing gestational sac in the upper uterine segment. The sac shows a single live fetus within it.
The internal Os is closed. **The cervix is adequate in length(5.0 cm).**
Both adnexae are clear.
The right uterine artery shows a normal flow pattern with RI = 0.78 and a PI = 1.70.
The left uterine artery shows a normal flow pattern with RI = 0.74 and a PI = 1.48.
The mean pulsatility index of the uterine arteries is 1.59 (within normal range).

Fetal:
Placenta: Forming anteriorly. Extends down towards the internal os, however doesnt span across it. Homogenous echopattern. No R.P. collection.
Liquor amnii is normal.
CRL= 58.3 mm corresponding to 12 wks 2 days+/- 3 days. EDD by USG is 02/08/2018
Cardiac activity is visualised and is normal. Approx. = 163 bpm.
Nasal bone is seen and measures 3.1 mm in length and appears normal.
Nuchal Translucency measures 0.9 mm thick (within normal range).
Intracranial lucency is within normal range.
Ductus venosus flow is normal.
No tricuspid regurgitation.
Fetal stomach bubble and fetal urinary bladder are visualised and are normal.

IMPRESSION: Single intrauterine pregnancy, corresponding to a gestational age of 12 wks 2 days +/- 6days.
Normal level 1 scan.

I, Dr. Sahil Loomba, declare that while conducting the ultrasound on Mrs. JYOTI KANYAL , i have neither detected nor disclosed the sex of her fetus to anybody in any manner.
Please note: All congenital anomalies cannot be detected on ultrasound.



**** End Of Report ****

Dr. SAHIL LOOMBA
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CONSULTANT RADIOLOGIST

Dr. SAHIL LOOMBA
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MOLQ™ LABORATORY

TEST REQUISTION FORM

Patient Details

First Name : Mrs Jyoti Last Name : Kanyal

Age : 30 years Gender : Male ☐ Female ☑

Address : ______

______ Contact No. : ______

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 : Scan Lab Diagnostics

Client ID : ______

Total Amount : ______

Amount Received : ______ Receipt No. : ______

Amount Balance / Due : ______

Payment via : ☐ CASH ☐ CHEQUE ☐ CREDIT

Specimen Type Received (For MolQ use only)

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

Other Sample Type / Source : ______

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)

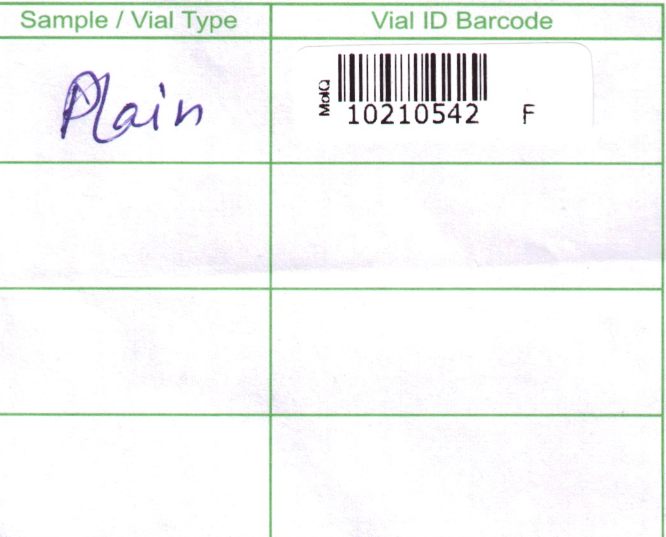
Double Marker

Instructions to Laboratory/Clinical Information

______

Sent Specimen Information

Temperature : ◯ Ambient ◯ Refrigerated ◯ Frozen



Sample / Vial Type	Vial ID Barcode
Plain	MolQ 10210542 F

Total No. of Vials/Container ______

Specimen Collection Information

Date: ______ Time : ______

Fasting : Yes ☐ No ☐ Fasting Period : ______ Hrs.

Collection by : Rajendra

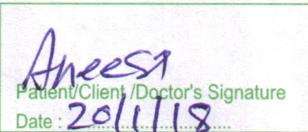
Urine Volume : ______ ml Hrs. ______

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 आवशयक 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 मोल्कयु 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 : 20/1/18

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For any query reach us at contact@molq.in; Customer care 9999 778 778; Laboratory 0124-4307906 For more info Log on to: www.molq.in

Annexure-III- Dual/ Triple/ Quadruple Marker Tests on Maternal Serum

Sr. No.	Pre-Requisites	Check Mark/ Remark
1	Name	Jyoti Kanyal
2	Date of Birth	01/08/1987
3	LMP	26/10/1987
4	Maternal Weight(Kg)	
5	Smoking Status	Yes No ✓
6	Diabetic Status	Yes No ✓
7	History of IVF [if Yes, please provide DOB of Donor]	Yes No ✓
8	Number of Fetus (Single/Twins)	Single
9	USG Report with radiologist name and degree.	
10	Origin(Asian ✓/ European African)	
11	Dual marker test(from 11 weeks to 13 weeks 6 days)	
12	Triple marker test (from 14 weeks to 21 weeks)	
13	Quadruple marker test (from 15 weeks to 22 weeks)	
14	Prev Trisomy Pregnancy	Yes No
15	Missed Abortion	

Form filled by (Name & Signature) Jyoti Kanyal

Patients Signature [signature]

Date 20/01/2018