ID → 7354

MOLQ™ LABORATORY

TEST REQUISTION FORM

Patient Details

First Name : Jyoti Last Name :

Age : 30 Gender : Male ☐ Female ☑

Address : Health Point diagnostics

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 : Health Point 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	☐ Bone Marrow	☐ CSF
☐ Plasma: EDTA/FL/OT	☐ 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 :

Received Specimen Information (For MolQ use only)

Temperature : ☐ Ambient ☐ Refrigerated ☐ Frozen

Date: 27/2/18 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)

(2) Triple marker

DOB - 01.01.1988

wt. 92.3 kgs.

Instructions to Laboratory/Clinical Information

Sent Specimen Information

Temperature : ☐ Ambient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
Serum	MolQ 10134544

Total No. of Vials/Container

Specimen Collection Information

Date: 27/2/18 Time :

Fasting : Yes ☐ No ☐ Fasting Period : Hrs.

Collection by : Harish

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

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PATIENTS NAME: JYOTI
DATE : 25/01 / 2018
OBSTETRICAL SCAN AND COLOR DOPPLER STUDY.

Single live foetus in **BREECH PRESENTATION** at time of scan.

Placenta is POSTERIOR UPPER SEGMENT. No retro placental clot. Grade 0 maturity. (Placental Thickness- 24 mm).

EVALUATION FOR CONGENITAL ANOMALIES – STRUCTURE CHECK LIST

1. Foetal Head	No ventriculomegaly / hydrocephalus No encephalocoele , No intra cranial cyst.
2. Foetal Neck	No cystic hygroma
3. Foetal Spine	No evidence of open spinal dysraphism. No scoliosis / kyphosis.
4. Foetal chest	Four chamber heart, Normal LVOT & RVOT. Diaphragm in normal position. (Foetal echocardiography is necessary if cardiac anomalies are suspected. The same is not under the preview of this scan)
5. Foetal abdomen	Stomach bubble is normally visualized. Both foetal kidneys are normal in position and size – No evidence of hydronephrosis. Foetal urinary bladder is normally visualized. The abdomen wall is normal. Foetal aorta is normal
6. Foetal limbs	All four limbs are visualized. No evidence of club foot.
7. Umbilical Cord	Shows one vein and two arteries.

(All congenital anomalies cannot and have not been excluded by this scan)

—>

M.D.C.

Dr. Mukul's
DIAGNOSTIC CLINIC
B-31, Shivalik, (Panchsheel Shivalik Main Road)
New Delhi 110017 Phone : 26692553, 26692...

Foetal cardiac activity is present. (FHR-146 bpm, Regular rhythm at time of scan)

OS is closed. Cervical length is adequate. (32 mm)

Amniotic fluid index : 4 QUAD. AFI- 15 cm

FOETAL MEASUREMENTS	SIZE	WEEKS	DAYS
BI PARIETANAL DIAMETER	42 MM	18 WKS	6 DAYS
HEAD CIRCUMFERENCE	161MM	19 WKS	0 DAYS
ABDOMINAL CIRCUMFERENCE	135MM	19 WKS	0 DAYS
FEMUR LENGTH	29 MM	19 WKS	0 DAYS

Foetal measurements corresponds to 19 wks + 0 days of gestation.

Estimated foetal weight at time of scan is 268 gms.

	S/D RATIO	RI	PI	REMARKS
Umbilical artery	2.46	0.58	0.88	**NORMAL**
Uterine artery	2.02	0.46	0.68	**NORMAL**
Foetal MCA	5.04	0.74	1.46	**NORMAL**

(CEREBRO-PLACENTAL RATIO >1) (PI OF MCA / PI OF UMB. ART)

NO CORD AROUND NECK SEEN AT TIME OF SCAN.

FOETAL MOVEMENTS AND TONE ARE NORMAL.

EDD (AS PER FOETAL SIZE) : 21/06/2018

IMPRESSION: SINGLE VIABLE INTRAUTERINE PREGNANCY CORROSPONDING TO 19 WKS + 0 DAYS OF GESTATION.

DECLARATION OF PREGNANT WOMEN

I, Mrs _____declare that by undergoing ultrasonography, I do not want to know the sex of the foetus.

Sign. Of pregnant women

DECLARATION OF DOCTOR

I, Dr R S Mukul declare that while conduction ultrasonography of this patient I have neither detected nor disclosed the sex of her foetus to any body in any manner.

Dr R. S. Mukul
M.B.B.S. (A.I.I.M.S.), M.D (Radio–Diagnosis)
~~Sr. Consultant Radiologist~~ Sonologist