MolQ™ LABORATORY

TEST REQUISITION FORM

Patient Details

First Name : Sumati Last Name : _____

Age : 45 Gender : Male ☐ Female ☑

Address : Amcare Hospital Zirakpur

_____ 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 : Amcare Hospital Zirakpur

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/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 :

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)

1) Uterine myoma
2) High ovary with Dermoid
3) Endometrial tissue.

Instructions to Laboratory/Clinical Information

Send Specimen Information

Temperature : ☐ Ambient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
	MolQ 10875182

Total No. of Vials/Container 3

Specimen Collection Information

Date: _____ Time : _____

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

Collection by : _____

Urine Volume _____ ml Hrs. _____

Patient Consent : I hereby authorized 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 publicity available further, I authorized 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 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 the 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 : मै 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 लिये 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 कराई जाए। इसके पश्चात मैं प्रयोगशाला को दोबारा अधिकृत करता हूँ कि जो नमूना जाँच के लिये उपलब्ध करवाया था, उसमें से बचे हुए नमूनो को प्रयोगशाला कभी भी और किसी भी समय किसी भी प्रकार के प्रयोग के लिये उपयोग में ला सकती है। शेष नमूनो को पूर्ण रूप से अंकित किया जाए और गुप्त रूप से रखा जाए और जब इसको नष्ट किया जाए तो पूर्ण रूप से नियम और विनियमता को उपयोग किया जाए। किसी भी प्रकार के मोल्क्यु प्रयोगशाला के प्रकाशन में रोगी की निजी जानकारियों को पूर्ण रूप में गुप्त रखा जायेगा। मैं सहमत हूँ कि मेरी मेडिकल रिकॉर्ड और बचे हुए नमूनो की नैदानिक प्रयोग और किसी भी प्रकार के अनुसंधान के लिये उपयोग में लिया जा सकता है।

अस्वीकृति : किसी भी जाँच सम्बन्धी शिकायत या जानकारी हेतु आप मोल्क्यु प्रयोगशाला को सम्पर्क कर सकते हैं, किसी भी प्रकार की कानूनी झगडे हेतु हमारा मुख्यालय देहरादून, उत्तराखण्ड है, किसी भी जाँच का मूल्य उसके दिए अधिकतम फुटकर मूल्य से अधिक नही होगा।

Patient/Client/Doctor's Signature
Date:.....

Diagno™ Labs

HISTOPATHOLOGY REQUISITION FORM

Name of Patient Sumati Devi Date of Birth/ Age 45yr

Sex: ☐ Male ☑ Female Lab Reference No. .....

Accession No. (For Lab use only) _____

Client Code _____ Date & Time of Sample collection _____

Telephone _____ Referring Doctor (Name & Tel No.) Dr Tejender Kaur 9878933868

Site of Specimen : ① uterine myoma ② Right ovary with Dermoid cyst ③ Endometrial tissue

Relevant Clinical History : c/o menorrhagia LMP-26/2/11

Additional Clinical and Relevant Data : _____

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

Clinical Diagnosis

Type of Specimen

☑ Large ☐ Medium ☐ Small ☐ IHC markers ☐ Special Stains

③ specimen sent for HPE

100 Histopath Slides / Block for review

No. of slides _____

No. of Blocks _____

Fixation

☐ Adequate

☐ Inadequate

Lynda

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 distilled water.
5. Volume of fixative should be atleast 10 times the volume of tissue.

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

AMCARE HOSPITAL

VIP Road, Zirakpur, Mohali (Punjab)

Patient's Name : _____ MR No. MR/21/004136 (IPD No. 7715)

UHID/MR No. : _____ Name: SUMATI DEVI

Department : _____ Age/Sex: 45 YRS / Female DOA: 13-Mar-21

Consultant: _____ Room : 217/PVT/2ND-FLOOR

Cons. Dr. TEJINDER KAUR

INITIAL ASSESSMENT AND PLAN OF (

Chief Complaints: c/o heavy periods – since 8 years.
K/c/o ovarian dermoid
on ? cyclical hormonal therapy since 8yrs.

TVS Pelvis (17/12/20) s/o Rt. ovarian dermoid 30 x 24 x 30mm,
wt. fibroid 4.9 x 4 x 3.5cm (R) lateral wall
ET 2.9 mm
L.O (N)

P2L2.
2 NVD
not sterilized
LMP 26/2/21
Med
Sx - Hemisalpingectomy
FU
Drug Allergy - Nil

GENERAL EXAMINATION

H.R. : _____ General condition : _____

B.P. : _____ Pallor : _____ Cyanosis: _____

Resp. Rate: : _____ Icterus : _____ Clubbing : _____

SPO_2 : _____ Lymphadenopathy : _____ Oedema feet : _____

Temp : _____ Bed Sores/ Deformity: _____

Any other significant finding : _____

PAIN ASSESSMENT:	Location	Pain Character	Pain Score	Frequency	Duration	Rerreral/Radiation

Height and weight of patient (BMI if patient is Obese): _____

Oral cavity: Dentation : _____

Oral hygiene : _____

PAST HISTORY

H/O Any Co-morbidities:

HTN		Asthma		CVA (Stroke)	
Diabetes Mellitus		Jaundice		TB	
Ischemic Heart Disease		Epilepsy		Leprosy	
Valvular Heart Disease		Hyper/Hypo Thyroidism		Malignancy	

Family History/Heredity:

H/O Allergy :

H/O Surgery :

H/O Blood Transfusions :

Any Bleeding Disorder :

Menstrual History :

Personal & Occupational History:

H/O Addictions:

Bowel / Bladder Complaints

- H/O Constipation
- Retention of Urine
- H/O Haematuria
- H/O Catheterization ☐ YES ☐ NO If Yes No. of Foleys Catheter used _____

& difficulties during catheterization : _____

H/O Medication

Other Relevant History

PLAN OF CARE

Care Plan: ☐ Conservative Treatment ☐ Under Observation ☐ Surgery Plan

Investigations Advice :

Nutritional Screening : ☐ Solid ☐ Semi Solid Normal ☐ Liquid ☑ NPO
☐ Hypertension ☐ Diabetic ☐ Renal ☐ Other _____

Preventive Aspects (Special Instructions)

Remarks

CA-125 to collect at 2 noon today

COVID 19 RT PCR - negative.

Provisional Diagnosis: - AUB
- Uterine Fibroid
- Rt ovarian dermoid cyst

Goals/Desired Outcomes Of Treatment:

Laparoscopic (R) ovarian cystectomy /
(R) oophorectomy
Myomectomy

We have counselled the patient/attendants about the progress / out come of the treatment.

Consultant Sign : Lynette **Date:** 13/5/21 **Time :** 10 AM

Signature of Patient/Relative Preeti. **Date:** 13/5/21 **Time :** 7 pm

NOTE:
1. Initial Assessment of patient can be performed by Medical Officer or by Treating Doctor.
2. Plan of care based on Initial Assessment will be documented by Treating doctor or the member of his team.
3. Counter sign of Treating Dotor on Initail Assesment and Plan of care within 24 Hrs is mendatory as per Hospital Policy.