



Unique Identifier

# TEST REQUISITION FORM

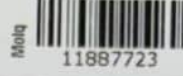
## Patient Details

First Name: Karnala Devi Last Name: 095373  
 Age: 70 Gender: Male  Female   
 Address: \_\_\_\_\_ Contact No. \_\_\_\_\_  
 E-mail ID: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Contact No. \_\_\_\_\_  
 For Maternal Screening -Date of Birth-        
 Weight: \_\_\_\_\_ kg. Height: \_\_\_\_\_ ft \_\_\_\_\_ inches, LMP: \_\_\_\_\_ Last Ultrasound Report

## Test Name/Test Code

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

1. HPV smear  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_  
 6. \_\_\_\_\_  
 7. \_\_\_\_\_  
 8. \_\_\_\_\_  
 9. \_\_\_\_\_



## Billing Information

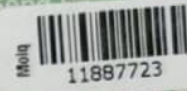
Client Name: Pash Rayali Hospital Rues  
 Client ID: \_\_\_\_\_  
 Total Amount: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_ Receipt No.: \_\_\_\_\_  
 Amount Balance /Due: \_\_\_\_\_  
 Payment via:  Cash  Cheque  Credit  ePlatform

## Instructions to Laboratory/Clinical Information

## Send to Information

To: \_\_\_\_\_  Ambient  Refrigerated  Frozen

Sample / Vial Type	Vial ID Barcode
<u>Cervix</u>	



## 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 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"/> Semen                   | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Other Sample Type/Source \_\_\_\_\_

## Received Specimen Information (For MolQ use only)

Temperature  Ambient  Refrigerated  Frozen  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Patient ID: \_\_\_\_\_ No. of Vials/container: \_\_\_\_\_

Total No. of Vials/Container: \_\_\_\_\_

## Specimen Collection Information

Date: 02/07/24 Time: 2:30  
 Fasting: Yes  No  Fasting Period: \_\_\_\_\_ Hrs.  
 Collection by: S K Rawal  
 Urine Volume: \_\_\_\_\_ ml Hrs. \_\_\_\_\_

1 \_\_\_\_\_ 2 \_\_\_\_\_

Signature of Accessioning Officer(s)

**Patient Consent:** I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my condition/disease information etc. as may be necessary to perform the test or services etc. Medical records/information to the extent 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. I agree to the access of my medical records and specimen for diagnostic and research purpose.

**Disclaimer:** The sample used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulation specified as applicable by law. In the event of any publication by MolQ Laboratory, Patient's identity will remain confidential. For any test/service related complaint/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurugram, Haryana. The financial liability or compensation of any sort is not more than MRP of the test requested.

**धरि सुगुणित** - मेरी शरीर संबंधित जानकारी का उपयोग करने के लिए मैंने अपने डॉक्टर को अधिकृत किया है। मैंने अपने डॉक्टर को अधिकृत किया है कि वह मेरी जानकारी को अपने डॉक्टर को दे सकते हैं और मेरी जानकारी को अपने डॉक्टर को दे सकते हैं। मैंने अपने डॉक्टर को अधिकृत किया है कि वह मेरी जानकारी को अपने डॉक्टर को दे सकते हैं। मैंने अपने डॉक्टर को अधिकृत किया है कि वह मेरी जानकारी को अपने डॉक्टर को दे सकते हैं।

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Date \_\_\_\_\_ Patient/Client/Doctor's Signature \_\_\_\_\_

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 For any query reach us at contact@molq.in: Customer care 9999 778 778: Laboratory 0124-4307906



# PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

Rajesh Pilot Chowk, Garhi Bolni Road, Rewari-123401 (Haryana), India

Phone No +91-1274-263300, 260021

E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC207727



Lab No: 

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## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Kamala devi Referring Doctor Dr. Manoj Yadav Date 02/07/24  
 Name \_\_\_\_\_ Date of Birth 70 Sex: Male / Female   
 IPD No \_\_\_\_\_ Collection Centre \_\_\_\_\_ Uhid No. 095973

Telephone \_\_\_\_\_ RCC \_\_\_\_\_  
 (if different)

Site of Specimen: Antrum

Relevant Clinical History:  
Epi-gastric pain

Additional Clinical and Relevant Data:  
 (Previous Biopsy/ FNAC/X-ray etc.) Clinical Diagnosis:

### Type of Specimen:

Large  Medium  Small

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Antral biopsy to R/O  
H. Pylori

Histopath Slides / Block for review:

### Fixation

Adequate   
 Inadequate

[Signature]  
 Doctor's Signature's  
 Dr. Manoj Yadav  
 MBBS, MD (Gold Medalist)  
 Pathology