TEST REQUISITION FORM

MOLQ® LABORATORY

Unique Identifier

Patient Details

First Name: Kamala 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:- D D M M Y Y Y Y

Weight: ____ kg. Height: ____ ft ____ Inches, LMP ____ Last Ultrasound Report

Billing Information

Client Name: Push Payali Hospital Rewa

Client ID:

Total Amount

Amount Received: Receipt No.:

Amount Balance /Due:

Payment via: ☐ Cash ☐ Cheque ☐ Credit ☐ ePlatform

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
☐ Semen	☐ 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. HPE Small
2.
3. Molq 11887723
4.
5.
6.
7.
8.
9.

Instructions to Laboratory/Clinical Information

Send Sample Information

Molq 11887723

Temperature ☐ Ambient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
Gallbladder	

Total No. of Vials/Container:

Specimen Collection Information

Date: 09/07/24 Time: 2:30

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

Collection by: S K Rewa

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 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.

[illegible]

Date ____ Patient/Client/Doctor's Signature

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

PUSHPANJALI HOSPITAL

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11887723

Lab No: | | | | | | | | |

HISTOPATHOLOGY REQUISITIONFORM

Patient Name kamala devi ReferringDoctor Dr. Manoj Yadav Date 02/07/24

Name _____ Date ofBirth 70 Sex: Male / Female

IPD No---------- CollectionCentre _____ Uhid No. 095373 OPD

Telephone _____ RCC _____ (ifdifferent)

Site of Specimen: Antrum

Relevant Clinical History:

Epigastric pain

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

Type of Specimen:

☐ Large ☐ Medium ☑ Small

Antral biopsy to R/o H. Pylori

Histopath Slides / Blockforreview:

☐ Miscellaneous
☐ IHCmarkers
☐ SpecialStains
☐ Microphotography

Fixation

☐ Adequate ☐ Inadequate

Docter's Signature's

Dr. Manoj Yadav (MD)
Pathology