

Unique Identifier

Test Name/Test Code

(Please refer to the Directory of Services for correct test name)

Patient Details

Name: Uma Rao Singh Last Name: 092923

96/M Gender: Male Female


Contact No. _____

ID: _____

Ref by: _____ Contact No. _____

External Screening-Date of Birth:

Weight: _____ kg Height: _____ inches LMP: _____

1
2 HPE Small
3
4 
5
6
7
8
9

Payment Information

Name: Pushpanjali Rawars

ID: _____

Amount: _____


Amount Received: _____ Receipt No. _____

Amount Balance/Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinical

Shipping Information

 Patient Refrigerated

Sample / Vial type _____ Via _____

Container

Specimen Type Received (For MolQ use only)

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

Sample Type/ Source: _____

Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

ID: _____ No. of vials/container: _____

1	2
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Signature of Accessioning Officer(s)

Total No. of Vials/Container: _____

Specimen Collection Information

Date 5/7/24 Time 9:00

Fasting: Yes No Fasting Period: _____

Collection by: Surender Kumar

Urine Volume: _____ ml

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information (including but not limited to any conditions) 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 used for the laboratory 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 information for research purposes.

The samples used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by MolQ Laboratory, patient's identity will remain confidential. For service related complaints/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurgaon, Haryana. No refund of any sort is not more than MRP of the test requested.

मैं यहाँ पर अपने व्यक्तिगत और चिकित्सा जानकारी को साझा करने के लिए अनुमति दे रहा हूँ। मेरी जानकारी को केवल मेरे चिकित्सा उपचार के लिए ही उपयोग में आना चाहिए। मेरी जानकारी को किसी भी प्रकार के अनुसंधान के लिए उपयोग में नहीं लाया जाएगा। मेरी जानकारी को किसी भी प्रकार के अनुसंधान के लिए उपयोग में नहीं लाया जाएगा। मेरी जानकारी को किसी भी प्रकार के अनुसंधान के लिए उपयोग में नहीं लाया जाएगा।

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PUSHPANJALI HOSPITAL



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

Lab No:

HISTOPATHOLOGY REQUISITION FORM

Patient Name Umrao Singh

Referring Doctor Dr. Manoj Yadav

Date 05/07/24

Name _____

Date of Birth 96

Sex: Male / Female

IPD No _____

Collection Centre _____

Uhid No. 092923

o/p

Telephone _____



RCC _____
(if different)

Site of Specimen:

Lower esophageal growth

Relevant Clinical History:

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

Lower esophageal growth biopsy
to R/O malignancy

Histopath Slides / Block for review:

Fixation

Adequate

Inadequate

Doctor's Signature's

Dr. Manoj Yadav
AM 6/24

