



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



Messing

HISTO PATHOLOGY REQUISITION SLIP

Date *18-7-24*

Name *Mrs Santosh*  *Bisanda*

Age *65.4* Sex *F* Address

Admission No.

Specimen *UHD 154028*  *03895* *8816081618*

Site

Relevant Clinical History

Cervical Bladder

Operative Note

Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

Clinical Finding and History..... LMP / Any other

Menstrual / Post Menopausal / Suspicious Lesion / Other

Site of Sample

Pre / Post coital, Lat Vag wall / endo Cervix

Ref. Dr.....



Unique Identifier

TEST REQUISITION FORM

Test Name/Test Code

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

1	
2	
3	HPE Small
4	
5	
6	
7	
8	
9	

Patient Details

Name: Santosh Last Name: 154028
65/F Gender: Male Female

Address: _____ Contact No: _____

Phone ID: _____

Ordered By: _____ Contact No: _____

Maternal Screening -Date of Birth: [][] [][] [][][][]

Weight: _____ kg Height: _____ Inches LMP: _____ Last Ultrasound Report

Referring Information

Name: Pushpanjali Rawar

ID: _____

Amount: _____

Ref Received: _____ Receipt No: _____

Payment Balance /Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinical Information

Specimen Information

Temperature: Ambient Refrigerated Frozen

Sample / Vial type: Contra Vial ID Barcode: _____

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 |

Original Sample Type/Source: _____

Received Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

ID: _____ No. of Vials/container: _____

1	2
---	---

Signature of Accessioning Officer(s)

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 18/7/24 Time: 9:00

Fasting: Yes No Fasting Period: _____

Collection by: _____

Urine Volume: _____ ml Hrs. _____

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 as per the extent applicable by laws and regulations. All test results, and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate research and use in the future. I agree to the access of my medical records and specimen for diagnostic and research purposes.

Any 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, I agree that 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. For any test/service related complaint/queries please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gulugum, Mysore. The financial liability of the test is on the patient.

Date: _____ Patient ID: _____

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



Ref No.	PDC/USG/OPC/UHID154028	Date	16-07-2024
Patient's Name	Mrs. Santosh	Age & Sex	65Y/F
Referred By	Dr. Neeraj	Test Done	USG-

ULTRASOUND REPORT OF WHOLE ABDOMEN

Liver is normal in size and echo-texture. No obvious focal lesion is seen in liver parenchyma. Intra hepatic biliary channels are not dilated **Portal vein** is normal **The CBD** is not dilated

Gall bladder is partially distended. A **floating calculus of size 10.8mm** is noted in lumen of gall bladder. .

Pancreas is normal in size & echotexture with no e/o focal lesion.

Spleen is normal in size and echotexture. No focal lesion is seen.

Right Kidney is normal in size, shape & echotexture. Cortico-medullary differentiation is well maintained. No e/o calculus or hydronephrosis is seen on right side. A **simple cyst of size 36x18mm** is noted in **mid pole of right kidney**.

Left Kidney is normal in size, shape & echotexture. Cortico-medullary differentiation is well maintained. No e/o calculus or hydronephrosis is seen on left side.

Urinary bladder is well distended. The lumen is echofree with no e/o any calculus or mass lesion.

Uterus is not visualized (Post Operative status).

No e/o ascites seen.

No e/o obvious abdominal lymphadenopathy is seen.

No USG e/o appendicitis is seen.

IMPRESSION :

- **Cholelithiasis.**
- **Right renal simple cyst.**

Adv: clinical correlation.

Dr. Ritesh Garg
MBBS MD (Radiodiagnosis)
Consultant Radiologist

PUSHPANJALI HOSPITAL

(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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

Phone No +91-1274-263300, 260021

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



Patient Name my Pantash UHID No. 15402A IPD No. 0389
Age / Sex 65yF Bed No. D.O.A 18-7-24 D.O.S 18-7-24

OPERATION THEATRE NOTES

Surgeon In-charge : Anesthetist :
Assistant Surgeon : OT Technician :
OT Staff : Type of Anaesthesia :
Pre-Operative Diagnosis : SYMPTOMATIC GALL STONE DISEASE
Post - Operative Diagnosis :
Procedure Name : LAP CHOLECYSTECTOMY
Operation Started at : Operation Finished at : Duration :
Sponge Count : Whome :

Operative Notes :

OT Findings -

1. GB distended
wall thickness (2)

2. A large stone noted
in GB lumen

3. cystic duct & artery
clipped

Organ Explained : GA

Specimen Sent for histopathology (if any) :

Immediate post-operative condition :

Surgeon's Signature :

Date & Time : (am /