

Unique Identifier

Test Name/Test Code

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

Patient Details

Patient Name: ABhay Singh - 1 Last Name: 152734

Age: 59/01 Gender: Male Female

Address: _____

Contact No: _____

Ref ID: _____

Ordered By: _____ Contact No: _____

Maternal Screening - (Date of Birth):

Weight: _____ Kg, Height: _____ ft _____ inches, LMP: _____ (Last Menstrual Period)


1 Tissue - 1

2 TB

3 PCR

4

5

6  11856017

7

8

9

Billing Information

Patient Name: Purkpanjali Rawar

Patient ID: _____

Insurance Amount: _____

Amount Received: _____ Receipt No: _____

Amount Balance/Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinical Information

Barcode Information

Barcode:  11856017 Refrigerated

Sample / Vial Type: _____ Vial ID B: _____

Container - 1

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/PT | <input type="checkbox"/> FN Aspirate | <input type="checkbox"/> Fluid |
| <input type="checkbox"/> SSI | <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"/> Swear | <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"/> Other's |

Other Sample Type/Source: _____

Received Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

Patient ID: _____ No. of Vials/Container: _____

1 _____ 2 _____

Signature of Accessioning Officer(s)

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 21/7/24 Time: 11

Fasting: Yes No Fasting Pa: _____

Collection by: _____

Urine Volume: _____ ml Hrs

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Lab No:

HISTOPATHOLOGY REQUISITION FORM

Patient Name Abhay Singh Referring Doctor Dr. Manoj Yadav Date 20/07/20
Age 59 Date of Birth 59 Sex: Male / Female
ID No _____ Collection Centre _____ Uhid No. 150734
Phone _____



of Specimen: IC valve biopsy

Relevant Clinical History:

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

? Neocercarial dermatitis

(Ulcers + edema + erythema of)

Size of Specimen:

Large Medium Small

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

IC valve biopsy for T.B. PCR

IC valve biopsy to R/O
Histopath Slides / Block for review:

T.B / IBD

Fixation
 Adequate
Inadequate

Doctor's Signature's
Dr. Manoj Yadav