



TEST REQUISITION FORM

Unique Identifier

Test Name/Test Code


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

1. _____

2. _____

3. HPE Small

4. _____

5.  11856709

6. _____

7. _____

8. _____

9. _____

Patient Details

First Name: Baby Last Name: 154160

Age: 36/F 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

Instructions to Laboratory/Clinical Info

Billing Information

Patient Name: Pushpanjali Rawari

Patient ID: _____

Total Amount _____

Amount Received: _____ Receipt No.: _____

Amount Balance /Due: _____

Payment via: Cash Cheque Credit ePlatform

Specimen Information

Temperature: Ambient Refrigerated Frozen

Sample / Vial type	Vial ID
<u>Center</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: 26/7/24 Time: 1

Fasting: Yes No Fasting P _____

Collection by: SK Rawari

Urine Volume: _____ ml Hrs.

1 _____ 2 _____

Signature of Accessioning Officer(s)

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 provide the best care to me and my family. This information will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate diagnostic and research purposes. 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, I agree to the access of my medical records and specimen for diagnostic and research purpose. 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 responsibility of the test requested shall remain with the patient.

MolQ Laboratory को अधिकृत करता हूँ कि मेरी पूर्ण व्यक्तिगत जानकारी अपनी किसी भी शाखा के साथ साझा कर सकती है मेरी बीमारी की हालत या चुबना का खुलासा अगर परीक्षण के संवाहन के लिये आवश्यक हो तो। मैं इस प्रकार की जानकारी को पूर्ण रूप से गुप्त रखा जाए और सार्वजनिक रूप से उपलब्ध न कराई जाए। इसके परवाह में प्रयोगशाला को बीमारी की जानकारी के बिना मेरे नमूने को प्रयोगशाला कभी भी फिल्टर भी नहीं करेगा और किसी भी प्रकार के प्रयोग के लिये उपयोग में ला सकती है। मैं सहमत हूँ कि मेरी मेडिकल रिकॉर्ड और बचे हुए नमूने को वैज्ञानिक प्रयोग और किसी भी अन्य नमूने को पूर्ण रूप से अर्पित किया जाए और गुप्त रूप से रखा जाएगा, जब इसको नष्ट किया जाएगा तो पूर्ण रूप से निवम और विनियमता का उपयोग किया जाएगा। किसी भी अन्य प्रयोगशाला के प्रकाशन में मेरी कोई निजी जानकारी को पूर्ण रूप से गुप्त रखा जाएगा। किसी भी अन्य सम्बन्धी शिकायत या जानकारी हेतु आप मोल्क प्रयोगशाला को सम्पर्क करें।

PATHOLOGY

Date	23/07/2024	Srl No.	68		
Name	Mrs. BABY	Age	32 Yrs.	Sex	F
Ref. By	SELF				

USG WHOLE ABDOMEN

Scan shows liver of normal echo pattern. No focal lesion is seen in the liver.

Intrahepatic bile ducts and CBD are not dilated.

Hepatic portal veins and the IVC appear normal in caliber

Gall bladder shows multiple calculi, largest of size 16.0 mm. Its wall thickness is normal.

Both kidneys are of normal size, shape and echo pattern. No calculus, growth or hydronephrotic changes seen in either kidney.

Spleen is of normal size and echo pattern.

Pancreas is of normal echopattern with no obvious focal lesion.

No evidence of Para-aortic lymphadenopathy seen.

Both domes are moving well with respiration.

Subdiaphragmatic spaces of both sides are clear.

Scans show anteverted uterus of normal echo pattern and contour.

Both the adnexae are clear.

No pelvic collection seen.

Bladder is full and does not show any intraluminal pathology.

IMPRESSION ⇒ Cholelithiasis.

ADV : Clinical Correlation and Further Evaluation.

Dr. SATISH PARKASH
MD (RADIO DIAGNOSTICS)
CONSULTANT RADIOLOGIST

Report is purpose of doctor only. Not for medico legal cases. If the result (s) is / are alarming or unexpected. The patient / consultant is advised to immediately for a recheck. All congenital anomalies can not be detected on ultrasound. This is only a professional opinion. It may kindly be confirmed by the patient / consultant.

For free home sample collection call : 09541661121
AMBULANCE SERVICE AVAILABLE



PUSHPANJALI HOSPITAL

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Phone No +91-1274-263300, 260021

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

28 Baby UHID No. : 154610 IPD No. : 04155
 36/F Bed No. D.O.A. 25/7/24 D.O.S. 25/7/24

OPERATION THEATRE NOTES

Surgeon : Anesthetist :
 Surgeon : OT Technician :
 Type of Anaesthesia :
 Pre Diagnosis : ACUTE CHOLECYSTITIS
 Intraoperative Diagnosis : LAP CHOLECYSTECTOMY
 Started at 3:20 pm Operation Finished at 4:10 pm Duration
 Assistant : Whome

Notes :

- OT Findings -
1. GB distended, wall thickened
 2. Multiple stones in GB lumen
 3. Calot's triangle anatomy
 4. Cystic duct and artery clipped

Explained
 Specimen Sent for histopathology (if any)
 Immediate post-operative condition
 Surgeon's Signature
 Date & Time (am / pm)