



Unique Identifier

# TEST REQUISITION FORM

## Test Name/Test Code

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

1	HPE Small
2	
3	
4	
5	
6	
7	
8	
9	

## Patient Details

First Name: Sharda Devi Last Name: 004344  
 Age: 55/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: \_\_\_\_\_ Lab. Cloned Patient

## Instructions to Laboratory/Clinical Information

\_\_\_\_\_

## Billing Information

Client Name: Pushpanjali Recaru  
 Client ID: \_\_\_\_\_  
 Total Amount: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_ Receipt No: \_\_\_\_\_  
 Amount Balance Due: \_\_\_\_\_  
 Payment via:  Cash  Cheque  Credit  ePlatform

## Specimen Information

Ambient  Refrigerated   
 Sample / vial Type: Cover 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/CI     | <input type="checkbox"/> TFL 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 Fxalade        | <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"/> Swab                   | <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: \_\_\_\_\_

1	2
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Signature of Accessioning Officer(s)

Total No. of Vials/Container: \_\_\_\_\_

## Specimen Collection Information

Date: 26/7/24 Time: 9:00

Fasting: Yes  No  Fasting Period: \_\_\_\_\_

Collection by: \_\_\_\_\_

Urine Volume: \_\_\_\_\_ ml Hrs: \_\_\_\_\_

**Patient Consent:** I hereby authorize MOLQ Laboratory to use and share with affiliates, the personal information provided for the purpose of specimen processing for use in the development of new tests and for research purposes. I agree to the use of my medical records and specimen for diagnostic and research purposes and will not be made publicly available. Further, I authorize the use of the following specimen for research purposes.

**Disclaimer:** This sample used for research will be tested to maintain confidentiality and will be discarded as per the terms and conditions specified in specimen by law. In the event of any collection by MOLQ Lab, we warrant that we will use the information for the purposes stated above and will not use it for any other purpose. For any additional research requirements, please contact MOLQ Laboratory for assistance. In case of any dispute the jurisdiction will be fixed (Mumbai, Maharashtra). The financial cost will be more than MSRP of the test requested.

**Test Results:** I hereby authorize the laboratory to use and share with affiliates, the personal information provided for the purpose of specimen processing for use in the development of new tests and for research purposes. I agree to the use of my medical records and specimen for diagnostic and research purposes and will not be made publicly available. Further, I authorize the use of the following specimen for research purposes.

**Disclaimer:** This sample used for research will be tested to maintain confidentiality and will be discarded as per the terms and conditions specified in specimen by law. In the event of any collection by MOLQ Lab, we warrant that we will use the information for the purposes stated above and will not use it for any other purpose. For any additional research requirements, please contact MOLQ Laboratory for assistance. In case of any dispute the jurisdiction will be fixed (Mumbai, Maharashtra). The financial cost will be more than MSRP of the test requested.

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 For any query reach us at [contact@molq.in](mailto:contact@molq.in), Customer care 9999 778 778, Laboratory 0124-4307906

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 DM Gastroenterology  
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 Pushpanjali Hospital, P



# PUSHPANJALI HOSPITAL



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Phone No +91-1274-263300, 260021

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

Lab No:

## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Sharda devi Referring Doctor Dr. Manoj Yadav Date 26/07/14  
 Name \_\_\_\_\_ Date of Birth 55/ Sex: Male / Female   
 IPD No \_\_\_\_\_ Collection Centre \_\_\_\_\_ Uhid No. 004344  
 Telephone \_\_\_\_\_  11856701 RCC \_\_\_\_\_ (if different) ofo

Site of Specimen: Antrum

Relevant Clinical History:

Epigastri 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

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Histopath Slides / Block for review:

Fixation

Adequate

Inadequate

Doctor's Signature's

Manoj  
 Dr. Manoj Yadav  
 MBBS, MD (Gastroenterology)  
 DM Gastroenterology  
 Reg. No. HH 17007  
 Pushpanjali Hospital Rewari