

Unique Identifier

Test Name/Test Code

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

Patient Details

First Name: Rajneesh Veri Last Name: 013076
 Age: 51/F Gender: Male Female
 Address: _____ Contact No: _____
 E-mail ID: _____
 Referred By: _____ Contact No: _____
 For Molecular Screening - Date of Birth: [] [] [] [] [] [] [] [] [] []
 Weight: _____ kg Height: _____ cm Inches: _____ LMR: _____ (Indebtedness Form)

Instructions to Laboratory/Clinical Information

Billing Information

Client Name: Pushpanjali Rewari
 Client ID: _____
 Total Amount: _____
 Amount Received: _____ Receipt No: _____
 Amount Balance/Due: _____
 Payment via: Cash Cheque Credit ePlatform

Information

Barcode: 11856698 Room Refrigerated

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/PLCIT | <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: _____

Sample / Vial Type	Vial ID Barcode
<u>Center</u>	

Total No. of Vials/Container: _____

Received Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen
 Date: _____ Time: _____
 Patient ID: _____ 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: _____

Signature of Accessioning Officer(s)

Patient Consent: I hereby authorize MOIQ Laboratory to use and share with affiliates, any personal information recorded but not limited to my (patient/ blood) information etc. all may be necessary to perform the test & communication in the event of any test and diagnosis. I will keep confidential and will not be made publicly available. I further authorize the use of the without specimens for diagnostic research and will not at any time in the future. I agree to the terms of my medical records and specimens for diagnostic and research purposes.
Disclaimer: This sample used for research will be tested to maintain confidentiality and will be destroyed as per the laws and regulations specified as applicable by law. In the event of any publication by MOIQ Laboratory, written permission for any test results related computer/ query please contact MOIQ Laboratory for permission. In case of any dispute the jurisdiction will be Head Office, Gurugram, Haryana. The financial liability is not not more than 50% of the test required.

Dr. Manoj Yadav
 MBBS MD Gold Medalist
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 Reg No. HN 1706
 Pushpanjali Hospital, Ra



PUSHPANJALI HOSPITAL



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Phone No +91-1274-263300, 260021

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

Lab No:

HISTOPATHOLOGY REQUISITION FORM

Patient Name Rajesh Devi Referring Doctor Dr. Manoj Yadav Date 26/07/24
 Name _____ Date of Birth 59 Sex: Male / Female
 IPD No _____ Collection Centre _____ Uhid No. 013074
 Telephone _____  11856698 RCC _____
 (if different)

Site of Specimen: Antrum

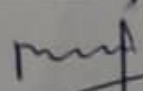
Relevant Clinical History: Epigastric pain

Additional Clinical and Relevant Data: OGD: Erosive Antral Gastritis

Type of Specimen:
 Large Medium Small
 Miscellaneous
 IHC markers
 Special Stains
 Microphotography

Antral biopsy to R/O H. Pylori

Histopath Slides / Block for review: _____
 Fixation
 Adequate
 Inadequate


 Doctor's Signature's
 Dr. Manoj Yadav
 MBBS, MD (Gold Medalist)
 DM Gastroenterology
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