



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

Lab No:

HISTOPATHOLOGY REQUISITION FORM

Patient Name Rodheshyam Referring Doctor Dr. Manoj Yadav Date 26/07/24
 Name _____ Date of Birth 45 Sex: Male / Female
 IPD No _____ Collection Centre _____ Uhid No. 154266

Telephone _____



RCC _____
(if different)

Site of Specimen:

D2 biopsy

Relevant Clinical History:

H/o Pain abc

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

OGD: Duodentis (7)
in D1
D2 (7)

Type of Specimen:

Large Medium Small

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

D2 biopsy to R/O (Gardner's)
Celiac disease

Histopath Slides / Block for review:

Fixation

Adequate

Inadequate

Manoj Yadav
 Doctor's Signature
 MBBS (General Medicine)
 DM Gastroenterology (Specialist)
 Reg No. MH 1706-
 Pushpanjali Hospital, Rewari



Unique Identifier

TEST REQUISITION FORM

Test Name/Test Code

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

1 _____

2 _____

3 **HPE Small**

4

5 _____

6 _____

7 _____

8 _____

9 _____

Pat Details

Name: **Radheshyam** Last Name: **154366**

Age: **45M** Gender: Male Female

Contact No: _____

By: _____ Contact No: _____

Small Screening - Date of Birth:

kg Height: _____ ft _____ inches LMP: _____ Last Observed Report

Referral Information

Referral Name: **Pushpanjali Rewari**

Received: _____ Receipt No: _____

Balance / Due: _____

Payment via: Cash Cheque Credit ePlatform

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/PL/CT	<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"/> Smear	<input type="checkbox"/> Urine
<input type="checkbox"/> W.Blood Hepatitis	<input type="checkbox"/> Slide (H&E)	<input type="checkbox"/> Stool
<input type="checkbox"/> W. Blood Sediment Citrate	<input type="checkbox"/> Pus	<input type="checkbox"/> Swab
<input type="checkbox"/> Semen	<input type="checkbox"/> Blood Culture Bottle	<input type="checkbox"/> Others

Specimen Collection Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

Signature: _____ No. of Vials/container: _____

Instructions to Laboratory/Clinical Information

Send Specimen Information

Ambient Refrigerated Frozen

Center

Vial ID Barcode

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. _____

Signature of Accessioning Officer(s)

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Discharge
Reg No /
Pushpanjali Hosp