



## TEST REQUISITION FORM

**Patient Details**

Unique Identifier: \_\_\_\_\_

First Name: Mukesh Kumar Last Name: 123899

Age: 52/M Gender: Male  Female

Address: \_\_\_\_\_

Contact No: \_\_\_\_\_

Referral ID: \_\_\_\_\_

Referral By: \_\_\_\_\_

Maternal Screening - Date of Birth: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ inches LMP: \_\_\_\_\_


**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 \_\_\_\_\_

**Billing Information**

Patient Name: Pushpanjali Rawar

Patient ID: \_\_\_\_\_

Bill Amount: \_\_\_\_\_

Amount Received: \_\_\_\_\_ Receipt No: \_\_\_\_\_

Amount Balance / Due: \_\_\_\_\_

Payment via:  Cash  Cheque  Credit  ePlatform

**Instructions to Laboratory/Clinical Information**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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/CLIC	<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: \_\_\_\_\_

**Information**

Temperature:  Ambient  Refrigerated  Frozen

Sample / Vial Type: Condor

Vial ID Barcode: \_\_\_\_\_

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

**Received Specimen Information (For MolQ use only)**

Temperature:  Ambient  Refrigerated  Frozen

Time: \_\_\_\_\_

Patient ID: \_\_\_\_\_ No. of Vials/Container: \_\_\_\_\_

1	2
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Signature of Accessioning Officer(s): \_\_\_\_\_

**Specimen Collection Information**

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

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

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

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

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my contact information, for the purpose of providing services to me and my family. I agree to the terms and conditions of the privacy policy and will not be held liable for any information provided. Further, I authorize the use of the following specimens for research purposes and as follows: \_\_\_\_\_

The sample used for research will be stored in a secure facility and will be destroyed as per the terms and conditions of the privacy policy. For any further information, please contact MolQ Laboratory. In case of any dispute, the jurisdiction will be placed on the Office, Gurugram, Haryana. The financial liability is on the patient.

I, \_\_\_\_\_, hereby authorize all relevant parties to use my personal information for the purpose of providing services to me and my family. I agree to the terms and conditions of the privacy policy and will not be held liable for any information provided. Further, I authorize the use of the following specimens for research purposes and as follows: \_\_\_\_\_

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# PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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Phone No +91-1274-263300, 260021

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

Lab No:

## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Mukesh Kumar Referring Doctor Dr. Manoj Yadav Date 26/02/24

Name \_\_\_\_\_ Date of Birth 52 Sex: Male / Female

IPD No \_\_\_\_\_ Collection Centre \_\_\_\_\_ Uhid No 123899

Telephone \_\_\_\_\_



RCC \_\_\_\_\_  
(if different)

*o/p*

Site of Specimen: Antrum

Relevant Clinical History:

Epigastric 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

*Manoj Yadav*  
Dr. Manoj Yadav  
MBBS, MD (Genl)  
DM Gastroenterology  
Reg No. H-17  
Pushpanjali H