



# PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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

Lab No:

## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Avraj Referring Doctor Dr. Manoj Yadav Date 26/07/24

Name \_\_\_\_\_ Date of Birth 5 Sex: Male / Female

IPD No \_\_\_\_\_ Collection Centre \_\_\_\_\_ Uhid No. 154348

Telephone \_\_\_\_\_



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

Site of Specimen: Rectum

Relevant Clinical History:

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

Sigmoidoscopy →  
erosion, u  
seen in rectum

Type of Specimen:

Large  Medium  Small

Miscellaneous

IHC markers

Special Stains

Microphotography

Histopath Slides / Block for review:

Rectal biopsy to R/O

infective / Inflammatory  
colitis

Fixation

Adequate

Inadequate

[Signature]  
Dr. Manoj Yadav  
MBBS, MD (Gold Medalist)  
Diploma in Gastroenterology  
Reg. No. [unclear]  
Pushpanjali Hospital




# TEST REQUISITION FORM

Unique Identifier

## Patient Details

First Name: Avi Raj Last Name: 154348  
 Age: 5/M Gender: Male  Female   
 Address: \_\_\_\_\_ Contact No: \_\_\_\_\_  
 E-mail ID: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Contact No: \_\_\_\_\_  
 For Maternal Screening - Date of Birth: [ ][ ] [ ][ ] [ ][ ] [ ][ ]  
 Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ inches LMP: \_\_\_\_\_ Last Menstrual Year: \_\_\_\_\_


## Test Name/Test Code

(Please refer to the Directory of Services for correct name and code)  
 1. HPE small  
 2.   
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_  
 6. \_\_\_\_\_  
 7. \_\_\_\_\_  
 8. \_\_\_\_\_  
 9. \_\_\_\_\_  
 10. \_\_\_\_\_

## Billing Information

Send Name: Pushpanjali Rawari  
 Send ID: \_\_\_\_\_  
 Bill Amount: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_ Receipt No.: \_\_\_\_\_  
 Amount Balance Due: \_\_\_\_\_  
 Payment via:  Cash  Cheque  Credit  ePlatform

## Instructions to Laboratory/Clinical Information

  Ambient  Refrigerated

Sample / Vial Type: \_\_\_\_\_ Vial ID Barcode: \_\_\_\_\_

Center

## 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/PLICIT     | <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"/> Pox                  | <input type="checkbox"/> Swab   |
| <input type="checkbox"/> Semen                  | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Other Sample Type/Source: \_\_\_\_\_

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

## Received Specimen Information (For MolQ use only)

Temperature:  Ambient  Refrigerated  Frozen  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Lot 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 flask

1. \_\_\_\_\_  
 2. \_\_\_\_\_

Signature of Accessioning Officers)

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 perform the test ordered by the above physician in compliance with laws and regulations, and to use such information for research purposes. I authorize the use of the laboratory equipment for immediate research and to store in the future. I agree to the storage of my medical records and specimens for diagnostic and research purposes. The sample used for research will be tested to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of use permission for MolQ Laboratory only. For any technical related consultancy please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Hoshiarpur, Jammu. The financial liability is on MBF of the test requested.

I hereby authorize all affiliates and MolQ Lab to use and share with affiliates, my personal information including but not limited to my condition/disease information etc. as may be necessary to perform the test ordered by the above physician in compliance with laws and regulations, and to use such information for research purposes. I authorize the use of the laboratory equipment for immediate research and to store in the future. I agree to the storage of my medical records and specimens for diagnostic and research purposes. The sample used for research will be tested to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of use permission for MolQ Laboratory only. For any technical related consultancy please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Hoshiarpur, Jammu. The financial liability is on MBF of the test requested.

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Date: \_\_\_\_\_ Patient/Client: \_\_\_\_\_  
 Signature of \_\_\_\_\_  
 Reg. No. \_\_\_\_\_  
 Pushpanjali Hospital