TEST REQUISITION FORM

MOLQ LABORATORY

Unique Identifier

Patient Details

Name: Umed Singh Yadav

Last Name

51/M

Gender : Male ☐ Female ☐

Address

Contact No.

Email ID

Referred By:

Contact No.

Maternal Screening -Date of Birth :

Wt: kg. Height: ft inches. LMP:

Last Ultrasound Report

Billing Information

Name: Pushpanjali Rewari

ID:

Amount

Amt Received: Receipt No:

Amt Balance Due:

Paid via: ☐ Cash ☐ Cheque ☐ Credit ☐ ePlatform

Specimen Type Received (For MolQ use only)

Serum	☐	Bone Marrow	☐	CSF	☐
Plasma: EDTA/FL/CIT	☐	FN Aspirate	☐	Fluid	☐
SST	☐	Tissue Formalin	☐	BAL	☐
W.Blood EDTA	☐	Paraffin Block	☐	Sputum	☐
W Blood Fluoride	☐	Smear	☐	Urine	☐
W Blood Heparin	☐	Slide (H&E)	☐	Stool	☐
W. Blood Sodium Citrate	☐	Pus	☐	Swab	☐
Semen	☐	Blood Culture Bottle	☐	Others	☐

Other Sample Type/Source

Received Specimen Information (For MolQ use only)

Temperature ☐ Ambient ☐ Refrigerated ☐ Frozen

Date: Time:

Courier ID: No. of Vials/container:

1	2

Signature of Accessioning Officer(s)

Test Name/Test Code

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

1.

2. HPE Small

3.

4.

5.

6.

7.

8.

9.

11856688

Instructions to Laboratory/Clinical Information

Sample Information

Type: ☐ Ambient ☐ Refrigerated

Sample / Vial Type	Vial ID Barcode
Conter	

Total No. of Vials/Container:

Specimen Collection Information

Date: 28/7/24 Time: 11:0

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 condition/disease information etc. as may be necessary to perform the test(s), the extent applicable by laws and regulations, will be kept confidential, and will not be made publicly available. Further, I authorize the use of the leftover specimens for reasonable research in the future. I agree to the access of my medical records and specimens for diagnostic and research purposes. Any sample used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulations applicable by law. In the event of any publication by MolQ Laboratory, for any test/service related complaint/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurugram, Haryana. The financial liability of the test requested

Date Patient

For any query reach us at contact@molq.in: Customer care 9999 778 778: Laboratory: 0124-4307906

For more info

Docter's Signature

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 REQUISITIONFORM

Patient Name Vinod Yadav — Referring Doctor Dr. Manoj Yadav — Date 27/07/24

Name _____ — Date of Birth 51 — Sex: Male / Female

IPD No _____ — Collection Centre _____ — Uhid No. 100456 OPD

Telephone _____ — 11856688 — RCC _____ (if different)

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
[ ] IHCmarkers
[ ] SpecialStains
[ ] Microphotography

Histopath Slides / Blockforreview:

Fixation

[ ] Adequate [ ]
Inadequate

Docter's Signature

Dr. Manoj Yadav
MBBS, MD (Gold Medalist)
DM Gastroenterology
Reg. No. HMC 57007
Pushpanjali Hospital