

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 Bimla devi Referring Doctor Dr. Manoj Yadav Date 27/07/24
Age 73 Sex: Male / Female
ID No. _____ Collection Centre _____ Uhid No. 154750 OPD
Phone _____
Barcode:  11856699
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:

Size 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

Manoj Yadav
Doctor's Signature's
Dr. Manoj Yadav
MBBS, MD (Gold Medalist)
DM Gastroenterology
Reg No. HN 17047
Pushpanjali Hospital, Rewari

Unique Identifier

Test Name/Test Code

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

Patient Details

Name: Bimla Devi Last Name: 194751
73/F Gender: Male Female

HPE Small



Contact No. _____

Ref ID: _____

Ref By: _____ Contact No. _____

Internal Screening (Date of Birth):

Weight: _____ kg Height: _____ inches LMP: _____ Last Menstrual Period

Instructions to Laboratory/Clinical Informant

Referring Information

Name: Pushpanjali Rawar

Ref ID: _____

Amount: _____

Ref Received: _____ Receipt No.: _____

Ref Balance Due: _____

Ref via: Cash Cheque Credit ePlatform

Send Specimen Information

Barcode: 11856689 Requisition Requisition Requisition
Vial ID Bar

Center

Specimen Type Received (For MoIQ use only)*

- | | | |
|---|---|---------------------------------|
| <input type="checkbox"/> Serum | <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> CSF |
| <input type="checkbox"/> Plasma EDTA/FLCIT | <input type="checkbox"/> FN Aspirate | <input type="checkbox"/> Fluid |
| <input type="checkbox"/> SST | <input type="checkbox"/> Tissue Formalin | <input type="checkbox"/> sM |
| <input type="checkbox"/> W Blood EDTA | <input type="checkbox"/> Papain Smear | <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&C) | <input type="checkbox"/> Tissue |
| <input type="checkbox"/> W Blood Sodium Citrate | <input type="checkbox"/> Pus | <input type="checkbox"/> Tissue |
| <input type="checkbox"/> Semen | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Other |

Ref Sample Type/Source: _____

Total No. of Vials/Container: _____

Received Specimen Information (For MoIQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

Ref ID: _____ No. of Vials/Container: _____

Specimen Collection Information

Date: 28/7/24 Time: 11

Fasting: Yes No Fasting Period: _____

Collection by: _____

Urine Volume: _____ ml Hrs: _____

Signature of Accessioning Officer(s): _____

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I hereby authorize MoIQ Laboratory to use and share with affiliates, my personal information including but not limited to my identification information and all data for the purpose of performing the services requested. My consent and registration will be used confidentially and will not be made publicly available. Further, I authorize the use of the above information for statistical analysis in the future. I agree to the access of my medical records and specimens for diagnostic and research purposes. For samples used for research will be subject to medical confidentiality and will be destroyed as per the rules and regulations specified in applicable law by the event of my submission to MoIQ Lab. For any further information, please contact MoIQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurgaon, Haryana. The above consent is given of my free will.