



PUSHPANJALI HOSPITAL

(A unit of Pushpanjali Medicare Pvt. Ltd.)

Rajesh Pilot Chowk, Garhi Bolni Road, Rewari - 123 401 (Haryana), India

Phone: +91-1274-260021, 260521, 260500

Email: pushpanjalihospitalrewari@gmail.com

CIN : U65110DL1987PTC207727

HISTO PATHOLOGY REQUISITION SLIP

Date 7/8/24

Name Naveen S/o _____

Age 25y Sex M Address _____

155488 Admission No. 83980666

4618

Specimen _____ Site _____



Brief relevant Clinical History

Hemorrhoid.

Brief Operative Note

Any Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

Clinical Finding and History _____ LMP / An _____

Normal / Post Menoposal / Suspicious Lesion / Other

Site of Sample

Cervix / Post fornix, Lat Vag wall / endo Cervix

Ref. Dr. _____

TEST REQUISITION FORM




Unique Identifier

[Blank Unique Identifier field]

Test Name/Test Code

(Please refer to the Directory of Services for details)

1. _____
2. HPE small
3. _____
4. 
5. _____
6. _____
7. _____
8. _____
9. _____

Patient Details

Name: Naveen Last Name: 155488
25/M Gender: Male Female

Address: _____ Contact No. _____

Ref ID: _____

Ordered by: _____ Contact No. _____

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

Weight: _____ kg. Height: _____ ft _____ inches, LMP _____ Last Ultrasound Report _____

Paying Information

Name: Pushpanjali Rewari

ID: _____

Amount: _____

Amount Received: _____ Receipt No.: _____

Amount Balance / Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinician

[Blank instructions area]

Specimen Information

Temperature: Ambient Refrigerated Frozen

Sample / Vial Type

Container

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/FL/CIT | <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 |

Sample Type / Source: _____

Received Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

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

1	2
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Signature of Accessioning Officer(s)

Total No. of Vials/Container

Specimen Collection Information

Date: 8/8/24

Fasting: Yes No

Collection by: Surender

Urine Volume: _____

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 required, to 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 research purposes in the future. I agree to the access of my medical records and specimens for diagnostic and research purpose. The samples used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law to the laboratory. For any test/analysis not listed on this form, please contact the laboratory.

