



Unique Identifier

TEST REQUISITION FORM

Test Name/Test Code

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

1 HPE Small

2

3

4

5

6

7

8

9

Patient Details

First Name: Jai Prakash Last Name: 131205

Age: 74M Gender: Male Female

Address: _____ Contact No: _____

Email ID: _____

Referred By: _____ Contact No: _____

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

Weight: _____ kg Height: _____ ft _____ inches, LMP: _____

Instructions to Laboratory/Clinical Information

Billing Information

Client Name: Rushpanjali Rewari

Client ID: _____

Bill Amount: _____

Amount Received: _____ Receipt No: _____

Payment Balance / Due: _____

Payment via: Cash Cheque Credit ePlatform

Temperature: Ambient Refrigerated Frozen

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/PLCIT	<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 Liquid EDTA	<input type="checkbox"/> Paraffin Block	<input type="checkbox"/> Sputum
<input type="checkbox"/> W Blood Flavoids	<input type="checkbox"/> Smear	<input type="checkbox"/> Urine
<input type="checkbox"/> W Blood Hepatitis	<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 / Vial Type	Vial ID Barcode
<u>Contca</u>	

Specimen Information (For MolQ use only)

Signature: _____

Temperature: Ambient Refrigerated Frozen

Time: _____

No. of Vials/Container: _____

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 9/8/24 Time: 9:00

Fasting: Yes No Fasting Period: _____ Hrs

Collection by: Surender Kumar Rewari

Urine Volume: _____ ml Hrs _____

Signature of Accessioning Officer(s)

1 _____ 2 _____

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Site of Sample
Cervix / Post fornix, Lat Vag wa

Date: _____ Patient/Clinician's Signature: _____



PUSHPANJALI HOSPITAL

(A unit of Pushpanjali Medicare Pvt. Ltd.)

Rajesh Pilot Chowk, Garhi Bohni Road, Rowari - 123 401 (Haryana), India

Phone: +91 1274 285021, 285021, 285000

Email: pushpanjalihospitalrowari@gmail.com

CIN: U85110DL1987PTC207727

HISTO PATHOLOGY REQUISITION SLIP

Consultant: Dr. Kamal Chugh

Date: 09/06/24

Name: Mr. Jai Parkash

Mo: 981 512 512

Age: 74yrs Sex: Male Address: Vill - Momalwas

UHPID: 13120C - IPD - 24-04-24
Cat - A/B

Admission No: 9812950711

Specimen



Site

Brief relevant Clinical History

Brief Operative Note

Resected specimen of Radical Cystectomy
along with distal ureteric margin

Any Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

Clinical Finding and History LMP / Any other

Normal / Post Menopausal / Suspicious Lesion / Other

Site of Sample

Cervix / Post fornix, Lat Vag wall / endo Cervix

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Ref. Dr.

