



PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

Rajesh Plot Chowk, Garhi Bolni Road, Rewari-123401 (Haryana), India

Phone No +91-1274-263300, 260021

E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC267727

Dr. P. Singh

HISTO PATHOLOGY REQUISITION SLIP

Date 12-8-26

Name Mrs. LALITA DEVI S/o W/o Kailash Chand

Age 56 Y Sex F Address Vill Raishrana

Admission No.

9012931987

UHID = 155386

280 06781



11856562

Specimen

Site

Brief Relevant Clinical History

Gall Bladder

Brief Operative Note

Any Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Pap smear

Clinical Finding and History

LMP / Any

Normal / Post Menopausal / Suspicious Lesion / Other

Site of Sample

Cervix / Post fornix, Lat Vag wall / endo Cervix

Ref. Dr.





Unique Identifier


TEST REQUISITION FORM

Patient Details

First Name: Lalita Devi Last Name: 155386
 Age: 56/F Gender: Male Female
 Address: _____ Contact No: _____
 E-mail ID: _____
 Referred By: _____ Contact No: _____
 For Maternal Screening -Date of Birth:
 Weight: _____ kg Height: _____ ft _____ inches LMP: _____ Last Ultrasound Report

Test Name/Test Code

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

1. HPE small
 2. _____
 3. _____
 4.  11056562
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____

Billing Information


Client Name: Pushpanjali Rewari
 Client ID: _____
 Total Amount: _____
 Amount Received: _____ Receipt No.: _____
 Amount Balance /Due: _____
 Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinical Information

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/FLCT | <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 Flavide | <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"/> Pts | <input type="checkbox"/> Swab |
| <input type="checkbox"/> Semen | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Other Sample Type/Source _____

 11856562 Ambient Refrigerated

Sample / Vial Type

Corder

Vial ID Barcode

Received Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen
 Date: _____ Time: _____
 Patient ID: _____ No. of Vials/container: _____

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 13/8/24 Time: 11:07
 Fasting: Yes No Fasting Period: _____
 Collection by: Surender Kumar Rewari
 Urine Volume: _____ ml Hrs: _____

1. _____ 2. _____
 Signature of Accessioning Officer(s)

Consent: 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 or a test/information in the event applicable to laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the following specimens for non-clinical research and to be used in any form in the future. I agree in the context of my medical records and specimen for diagnostic and research purposes.
 Release: The sample used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law, in the event of any publication by MolQ Laboratory, I am confidential. For any test/service related complain/issue please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurugram, Haryana. The financial liability or compensation shall be borne by the patient.

Disclaimer: The above information is subject to the terms and conditions of the test requisition form. The patient is responsible for providing accurate information. The laboratory is not responsible for any delay or error in the test results. The patient is advised to consult their physician for any medical advice. The laboratory is not a substitute for a physician's advice. The patient is advised to read the test requisition form carefully. The patient is advised to provide a valid contact number. The patient is advised to provide a valid email address. The patient is advised to provide a valid address. The patient is advised to provide a valid date of birth. The patient is advised to provide a valid gender. The patient is advised to provide a valid weight. The patient is advised to provide a valid height. The patient is advised to provide a valid LMP. The patient is advised to provide a valid specimen type. The patient is advised to provide a valid specimen source. The patient is advised to provide a valid specimen temperature. The patient is advised to provide a valid specimen date. The patient is advised to provide a valid specimen time. The patient is advised to provide a valid specimen patient ID. The patient is advised to provide a valid specimen no. of vials/container. The patient is advised to provide a valid specimen fasting status. The patient is advised to provide a valid specimen fasting period. The patient is advised to provide a valid specimen collection by. The patient is advised to provide a valid specimen urine volume. The patient is advised to provide a valid specimen ml hrs. The patient is advised to provide a valid specimen signature of accessioning officer(s). The patient is advised to provide a valid specimen date. The patient is advised to provide a valid specimen patient/clinician/doctor.

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Ref No.	PDC/USG/OPE/UHID155386	Date	06-08-2024
Patient's Name	Mrs. Lalita Devi	Age & Sex	56Y/F
Referred By	Dr. Neeraj	Test Done	USG-

ULTRASOUND REPORT OF WHOLE ABDOMEN

Liver is mildly enlarged in size 16.9cm and shows grade I fatty infiltration. No obvious focal lesion is seen in liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein is normal. The CBD is not dilated.

Gall bladder is contracted, however shows wall echo shadow complex-? Cholelithiasis. Adv:- review fasting after 3days of fat free diet.

Pancreas is normal in size & echotexture with no e/o focal lesion.

Spleen is normal in size and echotexture. No focal lesion is seen.

Right Kidney is normal in size, shape & echotexture. Cortico-medullary differentiation is well maintained. No e/o calculus or hydronephrosis is seen on right side.

Left Kidney is normal in size, shape & echotexture. Cortico-medullary differentiation is well maintained. No e/o calculus or hydronephrosis is seen on left side.

Urinary bladder is well distended. The lumen is echofree with no e/o any calculus or mass lesion.

UTERUS is postmenopausal in appearance. Endometrial thickness is 4 mms. Two hypoechoic lesions are seen in anterior and posterior wall of uterus, largest measuring 17.5x15.6mm in posterior wall s/o intramural uterine fibroids.

No e/o ascites seen.


No e/o obvious abdominal lymphadenopathy is seen.

No USG e/o appendicitis is seen.

IMPRESSION

- > Mild hepatomegaly with grade I fatty liver.
- > Gall bladder is contracted, however shows wall echo shadow complex-? Cholelithiasis. Adv:-review fasting after 3days of fat free diet.
- > Intramural uterine fibroids.

Adv: clinical correlation.


Dr. Ritesh Garg
MBBS MD (Radiodiagnosis)
Consultant Radiologist

No. 155386



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Patient Name : Ms Lalita Devi UHID No. : 155386 IPD No. : 24-04781
Age / Sex : 56/F Bed No. : _____ D.O.A. : 12/8/24 D.O.S : 12/8/24

OPERATION THEATRE NOTES

Surgeon In-charge : _____ Anesthetist : _____
Assistant Surgeon : _____ OT Technician : _____
OT Staff : _____ Type of Anaesthesia : _____
Pre-Operative Diagnosis : CHRONIC CHOLECYSTITIS
Post - Operative Diagnosis : _____
Procedure Name : LAP CHOLECYSTECTOMY
Operation Started at : _____ Operation Finished at : _____ Duration : _____
Sponge Count : _____ Whome : _____

Operative Notes :

- OT Findings -
1. Dense omental and duodenal adhesions noted to over GB and liver
 2. GB contracted, wall thickened
 3. GB lumen completely filled with stones
 4. Calot's triangle frozen
 5. Cystic duct stump sutured with PDS20

Organ Exploded : _____
Specimen Sent for histopathology (if any) : _____
Immediate post-operative condition : _____

Surgeon's Signature : _____
Date & Time : _____ (am / pm)