



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

Sumasti

Patient Name Sumasti

Referring Doctor Dr. Manoj

Date 16/08/24

Name _____

Date of Birth 57

Sex: Male / Female

IPD No _____

Collection Centre _____

Uhid No. 056/62

Telephone _____



RCC _____
(if different)

JPD

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

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Antral biopsy to R/O H. Pylori

Histopath Slides / Block for review:

Fixation

Adequate

Inadequate

Manoj
Doctor's Signature's
Dr. Manoj
AM Coastro

TEST REQUISITION FORM

Patient Details

Last Name: Sumati / First Name: 056162
 Age: 57/F Gender: Male Female
 Address: _____ Contact No: _____
 Email ID: _____
 Ordered By: _____ Contact No: _____
 Maternal Screening - Date of Birth: [][] [][] [][] [][]
 Height: _____ kg Height: _____ Inches, LMP: _____ Last Menstrual Period

Test Name/Test Code

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

HPE Skull



Referring Information

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

Instructions to Laboratory/Clinical Information

Specimen Type Received (For MolQ use only)

Serum	<input type="checkbox"/>	Bone Marrow	<input type="checkbox"/>	CSF	<input type="checkbox"/>
Plasma: EDTA/LCIT	<input type="checkbox"/>	FN Aspirate	<input type="checkbox"/>	Fluid	<input type="checkbox"/>
UET	<input type="checkbox"/>	Tissue Formalin	<input type="checkbox"/>	BAL	<input type="checkbox"/>
U Blood EDTA	<input type="checkbox"/>	Paraffin Block	<input type="checkbox"/>	Sputum	<input type="checkbox"/>
U Blood Plasma	<input type="checkbox"/>	Smear	<input type="checkbox"/>	Urine	<input type="checkbox"/>
U Sped Hepern	<input type="checkbox"/>	Slide (H&E)	<input type="checkbox"/>	Stool	<input type="checkbox"/>
U Sped Sodium Citrate	<input type="checkbox"/>	Pus	<input type="checkbox"/>	Swab	<input type="checkbox"/>
U Semen	<input type="checkbox"/>	Blood Culture Bottle	<input type="checkbox"/>	Others	<input type="checkbox"/>



Formulation

Ambient Refrigerated

Sample / Vial Type

Vial ID Barcode

Center

Received Specimen Information (For MolQ use only)

Status: Ambient Refrigerated Frozen
 Time: _____
 ID: _____ No. of Vials/containers: _____
 Signature of Accessioning Officer(s): _____

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 16/8/24 Time: 9:0
 Fasting: Yes No Fasting Period: _____
 Collection by: Surender Kumar Rawat
 Urine Volume: _____ ml Hrs: _____

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my name, address, telephone etc. as may be necessary to perform the test or to refer to the external agencies by laws and regulations, will be used confidentially and will not be made publicly available. Further, I authorize the use of the laboratory equipment for scientific research and to be done in the future. I agree to the access of my medical records and specimens for diagnostic and research purposes. A sample used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified by applicable law. In the event of any publication by MolQ Laboratory, I shall be mentioned by name. For any laboratory related temporary means contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be raised to New Delhi, India. The financial liability or complete RPO of the test requested.
