




Unique Identifier

TEST REQUISITION FORM

Test Name/Test Code

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

1. HPE Small - 1

2. 

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

Patient Details

First Name: Indrajit Last Name: 83591

Age: u/m 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: _____ (See Ultrasound Report)

Billing Information

Client Name: Pushpanjali Revani

Client ID: _____

Total Amount: _____

Amount Received: _____ Receipt No. _____

Amount Balance Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinical Information

Specimen Information

To:  Ambient Refrigerated

Sample / Vial Type	Vial ID Barcode
<u>Center</u>	

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/FLCIT	<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"/> Blood
<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

Other Sample Type/Source: _____

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: 24/8/24 Time: 11:00

Fasting: Yes No Fasting Period: _____

Collection by: _____

Urine Volume: _____ ml Hrs. _____

1	2
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Signature of Accessioning Officer(s)

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my contact information, information as may be necessary to perform the test and to communicate to the extent appropriate by law and regulations, will be kept confidential and will not be made publicly available. I authorize the use of the patient information for research purposes. The completed form received will be coded to ensure confidentiality and will be destroyed as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, the information will be coded to ensure confidentiality and will be destroyed as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, the information will be coded to ensure confidentiality and will be destroyed as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, the information will be coded to ensure confidentiality and will be destroyed as per the rules and regulations specified as applicable by law.

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Doctor's Signature's
[Signature]



PUSHPANJALI HOSPITAL



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Phone No +91-1274-263300, 260021

E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC207727

Lab No:

HISTOPATHOLOGY REQUISITIONFORM

Patient Name Inderjit

Referring Doctor Dr. Manoj Yadav

Date 23/08/24

Name _____

Date of Birth 41

Sex: Male / Female

IPD No _____

Collection Centre _____

Uhid No. 83591

Telephone _____



RCC _____
(if different)

Site of Specimen:

Rectal polyp

Relevant Clinical History:

Additional Clinical and Relevant Data:
(previous Biopsy/ FNAC/X-ray etc.) Clinical Diagnosis:

Sigmoidoscopy: Polypect
done

Type of Specimen:

Large Medium Small

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Rectal polyp to Rb

Histopath Slides / Block for review:

dysplasia

Fixation

Adequate

Inadequate

Doctor's Signature's

Dr. Manoj Yadav

AM Kalra