



PUSHPANJALI HOSPITAL

(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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HISTO PATHOLOGY REQUISITION SLIP

Date 23/8/2024

Name Rajesh Singh S/o.....

Age 53y Sex M Address.....

156283 Admission No. 996535173

Specimen 5193 Site.....



Relevant Clinical History

Cyst

Operative Note

Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

Relevant Finding and History..... LMP / Any other

Pre-menopausal / Post Menopausal / Suspicious Lesion / Other

Specimen Sample

Site: / Post fornix, Lat Vag wall / endo Cervix

Ref. Dr.....

Dr. Manoj
DM Health



Unique Identifier


TEST REQUISITION FORM

Test Name/Test Code

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

1. HPE small

2.

3. 

4.

5.

6.

7.

8.

9.

Patient Details

First Name: Rajesh Singh Last Name: 156283

Age: 53/M Gender: Male Female

Address: _____ Contact No: _____

E-mail ID: _____

Referred By: _____ Contact No: _____

For Maternal Screening -Date of Birth:

Weight: _____ kg Height: _____ Inches LMP: _____ Last Ultrasound Report

Instructions to Laboratory/Clinical Information

Billing Information

Client Name: Pushpanjali Rawar

Client ID: _____

Total Amount: _____

Amount Received: _____ Receipt No: _____

Amount Balance /Due: _____

Payment via Cash Cheque Credit ePlatform

Specimen Information

Referred Reingested



Sample / Vial: Conten Vial ID Barco: _____

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/CT	<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

Other Sample Type/Source: _____

Total No. of Vials/Container: _____

Received Specimen Information (For MolQ use only)

Temperature Ambient Refrigerated Frozen

Date: _____ Time: _____

Patient ID: _____ No. of Vials/Container: _____

Signature of Accessioning Officer(s): _____

Specimen Collection Information

Date: 24/8/24 Time: 11:00

Fasting: Yes No Fasting Period: _____

Collection by: _____

Urine Volume: _____ ml Hrs: _____

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Date: _____

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Dr. Masood