



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



HISTO PATHOLOGY REQUISITION SLIP

Date 23/8/2024

Name Poonam Upto Pawan Kumar

Age 36 y Sex F Address Bhaelp

155945
5222

Admission No. 9149601834

Specimen..... Site.....

Relevant Clinical History

① CERVICAL
Polyp- Endocervix



Relevant Operative Note

② Endometrial biopsy



Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

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

Pre-menopausal / Post Menopausal / Suspicious Lesion / Other

Site of Sample

Exterior / Post fornix, Lat Vag wall / endo Cervix

Ref. Dr.....



TEST REQUISITION FORM



Unique Identifier

Unique Identifier: _____


Test Name/Test Code

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

1 HPE small-1

2

3

4 

5

6

7

8

9

Patient Details

Name: Poonam -1 Last Name: 155945

36/F Gender: Male Female

Contact No: _____

By: _____ Contact No: _____

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

kg Height: _____ ft _____ Inches LMP: _____ Last (Obstet) Report

Instructions to Laboratory/Clinical Information

Referring Information

Name: Purhpanjali Rewar


Address: _____

Received: _____ Receipt No: _____

Balance /Due: _____

via: Cash Cheque Credit ePlatform

Send Specimen Information



Temperature: Ambient Refrigerate

Container: Conter

Vial ID: _____

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/CIT	<input type="checkbox"/> FN Aspirate	<input type="checkbox"/> Fluid
<input type="checkbox"/> TST	<input type="checkbox"/> Tissue Formalin	<input type="checkbox"/> BAL
<input type="checkbox"/> V.Blood EDTA	<input type="checkbox"/> Paraffin Block	<input type="checkbox"/> Sputum
<input type="checkbox"/> V Blood Fluoride	<input type="checkbox"/> Smear	<input type="checkbox"/> Urine
<input type="checkbox"/> V Blood Heparin	<input type="checkbox"/> Slide (H&E)	<input type="checkbox"/> Stool
<input type="checkbox"/> V 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 Type/Source

Send Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

No. of Vials/container: _____

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 24/8/24 Time: 9:30

Fasting: Yes No Fasting Period: _____

Collection by: _____

Urine Volume: _____ ml Hrs

1 _____ 2 _____

Signature of Accessioning Officer(s)

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