

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 REQUISITIONFORM

Patient Name Bimla Devi Referring Doctor Dr. Manoj Yadav Date 26/08/24
Name _____ Date of Birth 59 Sex: Male / Female
PD No _____ Collection Centre _____ Uhid No. 017205
phone _____  11856431 RCC _____
(if different)

Type 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
Antrol biopsy to RLS M. Pyan

Histopath Slides / Block for review:

Fixation
 Adequate
Inadequate

Doctor's Signature
Manoj Yadav
Dr. Manoj Yadav
MBBS, MD (Gold)
DM Gastroentero
Reg. No. HN 17
Pushpanjali Ho

TEST REQUISITION FORM



Unique Identifier

Test Name/Test Code

Please refer to the Directory of Services for code

HPE Small



Details

Bimla Devi
Salt

Last Name: 017205

Gender: Male Female

Contact No.:

Contact No.:

Screening -Date of Birth:-

kg Height: _____ inches LMP: _____

Last Ultrasound Report

Instructions to Laboratory/Clinic

Information

Pushpanjali Rawar

Information



Ambient

Received: _____ Receipt No.:

Price /Due:

Cash Cheque Credit ePlatform

Sample / Vial Type

Container

Sample Type Received (For MolQ use only)

- | | |
|---|---------------------------------|
| <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> CSF |
| <input type="checkbox"/> EDTA/FL/CIT | <input type="checkbox"/> Fluid |
| <input type="checkbox"/> Tissue Formalin | <input type="checkbox"/> BAL |
| <input type="checkbox"/> Paraffin Block | <input type="checkbox"/> Sputum |
| <input type="checkbox"/> Smear | <input type="checkbox"/> Urine |
| <input type="checkbox"/> Slide (H&E) | <input type="checkbox"/> Stool |
| <input type="checkbox"/> Pus | <input type="checkbox"/> Swab |
| <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Sample Type/Source

Total No. of Vials/Container: _____

Specimen Information (For MolQ use only)

Ambient; Refrigerated Frozen

Time: _____

No. of Vials/container: _____

Specimen Collection Information

Date: 26/8/24

Fasting Yes No

Collection by: _____

Urine Volume: _____

1

2

Signature of Accessioning Officer(s)

I 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 required applicable by laws and regulations, will be kept confidential, and will not be made publicly available. Further, I authorize the use of the leftover specimen for research. I agree to the access of my medical records and specimen for diagnostic and research purposes. For research use, the specimen will be stored for a period of 12 months and will be discarded as per the rules and regulations specified as applicable by law. In the event of any dispute, the jurisdiction will be Haryana. For further information please contact MolQ Laboratory. In case of any dispute the jurisdiction will be Haryana. For further information please contact MolQ Laboratory.

