


**TEST REQUISITION FORM**

**Test Name/Test Code**

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

1. \_\_\_\_\_  
 2. **HPE Small**  
 3. \_\_\_\_\_  
 4.  11856347  
 5. \_\_\_\_\_  
 6. \_\_\_\_\_  
 7. \_\_\_\_\_  
 8. \_\_\_\_\_  
 9. \_\_\_\_\_

**Patient Details**

First Name: **Shanti** Last Name: **157152**  
 Age: **67/F** Gender: Male  Female   
 Address: \_\_\_\_\_  
 Contact No. \_\_\_\_\_  
 Email ID: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Contact No. \_\_\_\_\_  
 Maternal Screening -Date of Birth: [ ] [ ] [ ] [ ] [ ] [ ]  
 Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ inches LMP: \_\_\_\_\_ Last Ultrasound Report

**Billing Information**

Patient Name: **Pushpanjali Rawari**  
 Patient ID: \_\_\_\_\_  
 Bill Amount: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_ Receipt No. \_\_\_\_\_  
 Amount Balance /Due: \_\_\_\_\_  
 Payment via:  Cash  Cheque  Credit  ePlatform

**Instructions to Laboratory/Clinical Int**

\_\_\_\_\_

**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"/> 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 Fluorider	<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

**Received Specimen Information (For MolQ use only)**

Temperature:  Ambient  Refrigerated  Frozen  
 Time: \_\_\_\_\_  
 Patient ID: \_\_\_\_\_ No. of Vials/container: \_\_\_\_\_

**Information**

 11856347  Patient  Refrige

Sample / Vial Type	Vial ID
<b>Contu</b>	

Total No. of Vials/Container: \_\_\_\_\_

**Specimen Collection Information**

Date: **11/2/24** Time: **1**  
 Fasting: Yes  No  Fasting Pt  
 Collection by: \_\_\_\_\_  
 Urine Volume: \_\_\_\_\_ ml Hrs.

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 condition/disease information etc. as may be necessary to provide to the extent applicable by laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate use in the future. I agree to the access of my medical records and specimens for diagnostic and research purpose. The sample used for research will be tested to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, for any test/service related complimentary please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurgaon, Haryana. The format of the test requisition.

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# PUSHPANJALI HOSPITAL



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Lab No:

## HISTOPATHOLOGY REQUISITION FORM

Patient Name Shanti Referring Doctor Dr. Manj Yadav Date 31/08/24  
 Name \_\_\_\_\_ Date of Birth 67 Sex: Male / Female   
 IPD No \_\_\_\_\_ Collection Centre \_\_\_\_\_ Uhid No. 157159  
 Telephone \_\_\_\_\_ RCC \_\_\_\_\_  
 (if different)

Site of Specimen: Rectum

Relevant Clinical History:

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

Sigmoidoscopy:  
Upper Rectal ex

Type of Specimen:

Large  Medium  Small  
 Miscellaneous  
 IHC markers  
 Special Stains  
 Microphotography

Histopath Slides / Block for review:

colitis / Fixation  
Infective colitis

Adequate  
 Inadequate

Doctor's Signature's

Dr. Manj Yadav