



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 REQUISITION FORM

Patient Name Bhupinder Singh Referring Doctor Dr. Manoj Yadav Date 09/

Name Chauhan Date of Birth 14 Sex: Male / Female

IPD No _____ Collection Centre _____ Uhid No. 1577

Telephone _____



RCC _____
(if different)

Site of Specimen: Antrum

Relevant Clinical History:

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

Type of Specimen:

Large Medium Small

- Miscellaneous
- IHC markers
- Special Stains
- Microphotograph

Antral biopsy to R/O H. Pylori

Histopath Slides / Block for review:

Fixation

Adequate
Inadequate



Unique Identifier

TEST REQUISITION FORM

Test Name/Test Code

(Please refer to the Directory of Services for

Patient Details

Name: Bhupender Singh Last Name: 157763

Age: 14/M Gender: Male Female

Address: _____ Contact No. _____

ID: _____

Order By: _____ Contact No. _____

Internal Screening -Date of Birth:-

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

1. HPE Small



Referring Information

Name: Pushpanjali Rewari

Address: _____

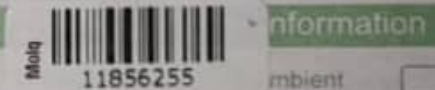
Phone Number: _____

Received: _____ Receipt No.: _____

Balance /Due: _____

Payment via: Cash Cheque Credit ePlatform

Instructions to Laboratory/Clinician



Sample / Vial Type

Contn

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/FLU/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 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 |

Sample Type/Source

Specimen Information (For MolQ use only)

Specimen Type: Ambient Refrigerated Frozen

Time: _____

No. of Vials/container: _____

1 _____ 2 _____

Signature of Accessioning Officer(s)

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 9/9/24

Fasting: Yes No

Collection by: _____

Urine Volume: _____

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my identification/health information etc. as may be required for 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 research purposes. I agree to the access of my medical records and specimen for diagnostic and research purposes. All specimens used for research will be coded to maintain confidentiality and will be discarded as per the rules and regulation specified as applicable by law. In the event of any problem or any test/service related complaint/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Haryana, Gurgaon, Haryana. The test requisitioned.

मैं यहाँ से अज्ञानता के बिना अपने व्यक्तिगत जानकारी, स्वास्थ्य जानकारी आदि का उपयोग और साझा करने के लिए MolQ Laboratory को और उसके संबन्धीतियों को अधिकृत करता हूँ। यह जानकारी कानून और विनियमों के दायरे में उपयोग की जा सकती है। मैं यह भी स्वीकार करता हूँ कि मेरी जानकारी गोपनीय है और इसे सुरक्षित रखा जाएगा। मैं यह भी स्वीकार करता हूँ कि मेरी जानकारी केवल मेरे चिकित्सा और शोध के लिए उपयोग की जाएगी। मैं यह भी स्वीकार करता हूँ कि मेरी जानकारी केवल मेरे चिकित्सा और शोध के लिए उपयोग की जाएगी। मैं यह भी स्वीकार करता हूँ कि मेरी जानकारी केवल मेरे चिकित्सा और शोध के लिए उपयोग की जाएगी।