



PUSHPANJALI HOSPITAL



TEST REQUISITION FORM



Unique Identifier

Unique Identifier: _____


Test Name/Test Code

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

1. _____

2. HPE Small

3. _____

4.  11934429

5. _____

6. _____

7. _____

8. _____

9. _____

Patient Details

First Name: vivek Last Name: 039605

Age: 21M Gender: Male Female

Address: _____

Contact No: _____

E-mail ID: _____

Referred By: _____ Contact No: _____

For Maternal Screening -Date of Birth:-

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

Instructions to Laboratory/Clinical Information

Instructions to Laboratory/Clinical Information

Billing Information

Client Name: Pushpanjali Rawari

Client ID: _____

Total Amount: _____

Amount Received: _____ Receipt No.: _____

Amount Balance /Due: _____

Payment via: Cash Cheque Credit ePlatform

Specimen Information

Sample / Vial type: _____ Ambient Refrigerated Frozen

Sample / Vial type	Vial ID Barcode
<u>Conten</u>	

Specimen Type Received (For MoIQ 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

Other Sample Type/Source: _____

Total No. of Vials/Container: _____

Received Specimen Information (For MoIQ use only)

Temperature: Ambient Refrigerated Frozen

Date: _____ Time: _____

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

Specimen Collection Information

Date: 6/2/25 Time: 10:30

Fasting: Yes No Fasting Period: _____ Hrs

Collection by: _____

Urine Volume: _____ ml Hrs _____

1	2
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Signature of Accession Officer(s)

Patient Consent: I hereby authorize MoIQ 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 perform the test or services etc. My records/information 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 structure research and in future research of kind and at any time in the future. I agree to the access of my medical records and specimen for diagnostic and research purpose.

Disclaimer: The sample 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 publication by MoIQ Laboratory, Patient's identity remain confidential. For any test/service related complaint/query please contact MoIQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Gurugram, Haryana. The financial liability or compensation of an amount more than MRP of the test requested.

MOLOQ: It is hereby declared that all the information provided in this form is true and correct to the best of my knowledge and belief. I understand that any false information provided may lead to the cancellation of the test and may result in the patient being charged with a crime. I agree to the terms and conditions of the test and understand that the results of the test may be used for research purposes. I understand that the results of the test may be used for research purposes. I understand that the results of the test may be used for research purposes.

Date: _____ Patient/Client/Doctor's Sign: _____

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PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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Phone No +91-1274-263300, 260021

E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC207727

Lab No:

HISTOPATHOLOGY REQUISITIONFORM

Patient Name Virek Referring Doctor Dr. Manoj Yadav Date 05/02/25
 Name _____ Date of Birth 21 Sex: Male / Female
 IPD No _____ Collection Centre _____ Uhid No. 039605 *OPD*

Telephone _____



RCC _____
(if different)

Site of Specimen: Antrum

Relevant Clinical History:

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

Type of Specimen:

Large Medium Small

Antbal biopsy to Rb H. pylori

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Histopath Slides / Block for review:

Fixation

Adequate
Inadequate

Doctor's Signature's

Manoj
Dr. Manoj Yadav
MBBS, MD (Gold Medal)
DM Gastroenterology
Reg No. HN 17067
Pushpanjali Hospital, R

patient ID : UHID039605
patient Name : VIVEK LUHANIWAL
age/Gender : 21Yrs, Male

Visit Date : 05/02/2025
Referred by : Dr. Navdeep Yadav
Consulted by : Dr Manoj Yadav

UPPER GI ENDOSCOPY Report

Informed consent was obtained from the patient after explaining all the benefits and risks of the procedure which the patient appeared to understand and so stated. The patient was connected to the monitoring devices and placed in left lateral position. The Endoscope (Olympus GIF 170) was advanced under direct visualisation.

remedication : Xylocaine spray LA

esophagus : Diaphragmatic hiatus at 40 cm, pgf at 39 cm, z line at 39 cm

GE Junction : 39 Cm, Hills grade 1

stomach :

Fundus : Normal

Body : Normal

Antrum : Mild erythema seen

Pylorus : Normal

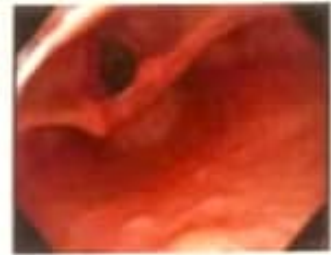
duodenum :

D1 : Normal

D2 : Normal

Biopsy : Taken from antrum

Impression : Mild antral gastritis, RUT +ve



Dr Manoj Yadav
MBBS, MD (Gold medalist),
DM Gastroenterology

Captured by IPro - www.ambalsoft.com