



# TEST REQUISITION FORM

Unique Identifier

[Blank Unique Identifier Box]

## Patient Details

First Name: Rameshwar Deyal Last Name: 005798  
 Age: 77M Gender: Male  Female   
 Address: \_\_\_\_\_  
 Contact No: \_\_\_\_\_  
 E-mail ID: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Contact No: \_\_\_\_\_  
 For Maternal Screening -Date of Birth- [ ][ ][ ][ ][ ][ ]  
 Weight: \_\_\_\_\_ kg, Height: \_\_\_\_\_ m, Inches, LMR: \_\_\_\_\_ Use Ultrasound Report

## Billing Information

Client Name: Pushpanjali Rawari  
 Client ID: \_\_\_\_\_  
 Total Amount: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_ Receipt No: \_\_\_\_\_  
 Amount Balance /Due: \_\_\_\_\_  
 Payment via:  Cash  Cheque  Credit  ePlatform

## 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/CLT	<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"/> Paps	<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  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Patient ID: \_\_\_\_\_ No. of Vials/container: \_\_\_\_\_

1	2
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Signature of Accessioning Officer(s)

## Test Name/Test Code

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

1. \_\_\_\_\_  
 2. HPE Small  
 3. \_\_\_\_\_  
 4.  11934418  
 5. \_\_\_\_\_  
 6. \_\_\_\_\_  
 7. \_\_\_\_\_  
 8. \_\_\_\_\_  
 9. \_\_\_\_\_

## Instructions to Laboratory/Clinical Information

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Specimen Information

7  11934418  
 Substrate / Vial Type  Ambient  Refrigerated  Frozen

Substrate / Vial Type	Vial ID Barcode
<u>Container</u>	

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

## Specimen Collection Information

Date: 7/2/25 Time: 2:30  
 Fasting: Yes  No  Fasting Period: \_\_\_\_\_ Hrs  
 Collection by: \_\_\_\_\_  
 Urine Volume: \_\_\_\_\_ ml Hrs \_\_\_\_\_

**Patient Consent:** I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my address, telephone number, email, and other contact information for the purpose of providing services, conducting research, and for other purposes. I understand that this information may be used for other purposes in the future. I agree to the use of my personal information and consent to the diagnosis and research purposes.

**Disclaimer:** The sample used for research will be stored permanently and will be disposed of per the rules and regulations specified as applicable to use. In the event of any publication by MolQ Laboratory, Patient's identity will remain confidential. For any laboratory-related correspondence please contact MolQ Laboratory for assistance. In case of any dispute the jurisdiction shall be New Delhi, India.

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## HISTO PATHOLOGY REQUISITION SLIP

Consultant - Dr. Neeraj

Date 06/02/2025

Name Mr. RAMESHWAR DAVAL S/o MANIRAM

Age 77 yrs Sex Male Address Vill. Rajpura Khalla

UHID - 005798, IPD - 24-11139 Mobile 839893294

Cat - ECHS

Specimen Sebacous cyst Site 11934418



Brief Relevant Clinical History

Sebacous cyst

Brief Operative Note

Any Relevant Special Investigation

## CYTOLOGY REQUISITION SLIP

Cytology Papsmear

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

Normal / Post Menoposal / Suspicious Lesion / Other

Site of Sample

Cervix / Post fomix, Lat Vag wall / endo Cervix

Ref. Dr. 

