PUSHPANJALI HOSPITAL

(A Unit of Pushpanjali Medicare Pvt. Ltd.)
Rajesh Pilot Chowk, Garhi Bolni Road, Rewari-123401 (Haryana), India
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Lab No: [ ][ ][ ][ ][ ][ ][ ][ ]

HISTOPATHOLOGY REQUISITIONFORM

Patient Name Gayatri devi | Referring Doctor Dr. Manoj Yadav | Date 06/02/25

Name _____ | Date of Birth 27 | Sex: Male / Female

IPD No _____ | Collection Centre _____ | Uhid No. 168189 IPD

Telephone _____ | RCC _____ (if different)

Site of Specimen: 1) IC valve biopsy

Relevant Clinical History: 2) Hepatic flexure Biopsy (colonic)

11934420

11934419

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

Type of Specimen:

- [ ] Large
- [ ] Medium
- [x] Small
- [ ] Miscellaneous
- [ ] IHCmarkers
- [ ] SpecialStains
- [ ] Microphotography

1) IC valve biopsy to look for T.B. PCR

Histopath Slides / Blockforreview:

Fixation

- [ ] Adequate
- [ ] Inadequate

2) Colonic biopsy to look for T.B./crohn's disease

Dr. Manoj Yadav
MBBS, MD (Gen. Medicine)
DM (Gastroenterology)
Reg. No. HN 17...
Pushpanjali Hospital, Rewari

Docter's Signature's

TEST REQUISITION FORM

MOLQ LABORATORY

Unique Identifier

Patient Details

First Name: Jayatri Devi-1 Last Name: 168189

Age: 27/F 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 Result

Billing Information

Client Name: Pushpanjali Relxari

Client ID:

Total Amount:

Amount Received: Receipt No :

Amount Balance /Due:

Payment via: ☐ Cash ☐ Cheque ☐ Credit ☐ ePlatform

Specimen Type Received (For MolQ use only)

☐ Serum	☐ Bone Marrow	☐ CSF
☐ Plasma: EDTA/FL/OIT	☐ FN Aspirate	☐ Fluid
☐ SST	☐ Tissue Formalin	☐ BAL
☐ W.Blood EDTA	☐ Paraffin Block	☐ Sputum
☐ W.Blood Fluoride	☐ Smear	☐ Urine
☐ W.Blood Heparin	☐ Slide (H&E)	☐ Stool
☐ W. Blood Sodium Citrate	☐ Pus	☐ Swab
☐ Semen	☐ Blood Culture Bottle	☐ 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

Signature of Accessioning Officer(s)

Test Name/Test Code

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

1. T.B PCR- 1
2. [redacted]
3.
4. Male 11934420
5.
6.
7.
8.
9.

Instructions to Laboratory/Clinical Information

Specimen Information

T: Male 11934420 bient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
Conter	

Total No. of Vials/Container:

Specimen Collection Information

Date: 7/2/25 Time: 10:30

Fasting: Yes ☐ No ☐ Fasting Period: Hrs.

Collection by:

Urine Volume: ml Hrs

Patient's/Guardian's Signature

Scanned with OKEN Scanner