



# PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)

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Lab No:

## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Cayatri 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)



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

Type of Specimen:

Large  Medium  Small

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

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Histopath Slides / Block for review:

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

Fixation

Adequate

Inadequate

*[Signature]*  
 Dr. Manoj Yadav  
 MBBS, MD (Gold Medalist)  
 DM (Histopathology)  
 Reg No. HN 1716  
 Pushpanjali Hospital, Rewari

Doctor's Signature's



# 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. T.B PCR - 1

2. ~~\_\_\_\_\_~~

3. \_\_\_\_\_

4. 11934420

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

## Patient Details

First Name: Snayatai Devi - Last Name: 168189

Age: 21/F Gender: Male  Female

Address: \_\_\_\_\_

Contact No: \_\_\_\_\_

E-mail ID: \_\_\_\_\_

Referred By: \_\_\_\_\_ Contact No: \_\_\_\_\_

For Maternal Screening -Date of Birth-

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ g Inches LMP: \_\_\_\_\_ Last Ultrasound Report: \_\_\_\_\_

## 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: Container

Temperature:  Ambient  Refrigerated  Frozen

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

## 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/FLCIT      | <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 (HSE)          | <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 |

## Received Specimen Information (For MolQ use only)

Temperature:  Ambient  Refrigerated  Frozen

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient ID: \_\_\_\_\_ No. of Vials/container: \_\_\_\_\_

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. \_\_\_\_\_

Signature of Accessioning Officer(s)

1. \_\_\_\_\_

2. \_\_\_\_\_

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my name, address, telephone number, as may be necessary to perform the test or services you provide. I understand that the above information will be used for the purpose of providing you with the best possible service. I further understand that the use of the above information for secondary purposes is subject to your consent. I agree to the terms of my medical records and consent for diagnostic and research purposes.

This sample used for research will be stored to maintain confidentiality and will be disposed as per the rules and regulations specified as applicable to you. In the event of any information by MolQ Laboratory, Patient records will be confidential. For any information related to privacy please contact MolQ Laboratory for assistance. In case of any dispute for procedure please read OTCB Consent. MolQ. The Requester/Collector/submitter of the sample is responsible for the test requested.

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