

# TEST REQUISITION FORM



Unique Identifier

\_\_\_\_\_

## Test Name/Test Code

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

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

2. HPESmall

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

4.  \_\_\_\_\_

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

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

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

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

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

## Patient Details

First Name: JagRam Last Name: 023460

Age: 87M 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

## Billing Information

Client Name: Pushpanyali Rawari

Client ID: \_\_\_\_\_

Total Amount: \_\_\_\_\_

Amount Received: \_\_\_\_\_ Receipt No: \_\_\_\_\_

Amount Balance /Due: \_\_\_\_\_

Payment via:  Cash  Cheque  Credit  ePlatform

## Instructions to Laboratory/Clinical Information

\_\_\_\_\_

\_\_\_\_\_

## 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/FL/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: \_\_\_\_\_

## Specimen Information

Temperature:  Ambient  Refrigerated  Frozen

Sample / Vial Type	Vial ID Barcode
<u>Center</u>	

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

## 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)

## Specimen Collection Information

Date: 8/2/24 Time: 19:30

Fasting: Yes  No  Fasting Period: \_\_\_\_\_ Hrs.

Collection by: \_\_\_\_\_

Urine Volume: \_\_\_\_\_ ml Hrs. \_\_\_\_\_

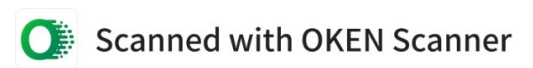
**Patient Consent** - I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my condition/disease information etc. as may be necessary to perform the test or services etc. Medical confidentiality to the extent applicable by laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate research and in future research of any 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:** This 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 MolQ Laboratory, Patient's Identity will remain confidential. For any test/service related compliance/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office - Gurugram, Haryana. The financial liability or compensation of any sort, shall remain with MRP of the test requested.

**Signature of Patient/Client/Doctor**

\_\_\_\_\_

Date: \_\_\_\_\_ Patient/Client/Doctor's Signature





# PUSHPANJALI HOSPITAL



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Lab No:

## HISTOPATHOLOGY REQUISITIONFORM

Patient Name Jagran

Referring Doctor Dr. Manoj Yadav

Date 07/02/25

Name Jagran

Date of Birth 87

Sex: Male / Female

IPD No \_\_\_\_\_

Collection Centre \_\_\_\_\_

Uhid No. 023460

*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

Miscellaneous

IHC markers

Special Stains

Microphotography

Antral biopsy to Rb H. pylori

Histopath Slides / Block for review:

Fixation

Adequate

Inadequate

Dr. Manoj Yadav  
MBBS, MD (Gold Medalist)  
DM Gastroenterology

Reg. No. HN 11097  
Pushpanjali Hospital, Rewari

Doctor's Signature's



Patient ID : UHID023460 Visit Date : 07/02/2025  
 Patient Name : JAG RAM SINGH YADAV Referred by : Dr. Navdeep Yadav  
 Age/Gender : 87Yrs, Male 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.

Pre-medication : Xylocaine spray LA

Esophagus : Kodsi grade 2 candidiasis, LA Grade C Esophagitis, Hiaphragmatic hiatus at 40 cm, pgf at 39 cm, z line at 39 cm

EG Junction : 39 Cm, Hills grade 2

Stomach :

Fundus : Normal

Body : Normal

Antrum : Erosive antral gastritis, Few superficial ulcers

Pylorus : Normal

Duodenum :

D1 : Multiple superficial ulcers seen

D2 : Multiple superficial ulcers seen

Biopsy : Taken from antrum

Impression : Kodsi grade 2 candidiasis, LA Grade C Esophagitis, Erosive antral gastritis, RUT +ve, Multiple superficial ulcers seen in stomach and duodenum



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MBBS, MD (Gold medalist),  
DM Gastroenterology