


TEST REQUISITION FORM



Unique Identifier

Test Name/Test Code

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

1 _____
 2 HPE Large
 3 _____
 4 
 5 _____
 6 _____
 7 _____
 8 _____
 9 _____

Patient Details


First Name: Shakuntala Last Name: 168140
 Age: 56/F Gender: Male Female
 Address: _____ Contact No: _____
 Email ID: _____
 Referred By: _____ Contact No: _____
 for Maternal Screening - Date of Birth: [][] [][] [][] [][]
 Height: _____ kg Height: _____ Inches LMP: _____ Last Menstrual Period

Instructions to Laboratory/Clinical Information

Billing Information

Client Name: Ashpanjali Pawar
 Client ID: _____
 Total Amount: _____
 Amount Received: _____ Receipt No.: _____
 Amount Balance / Due: _____
 Payment via: Cash Cheque Credit ePlatform

Send Specimen Information

 Patient Refrigerated Frozen
 Sample / vial type: Cover Vial ID Barcode: _____

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/PLCIT	<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 Hepath	<input type="checkbox"/> Slide (H&E)	<input type="checkbox"/> Stool
<input type="checkbox"/> W Blood Sodium Citrate	<input type="checkbox"/> Pua	<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 MolQ use only)

Temperature Ambient Refrigerated Frozen
 Date: _____ Time: _____
 Patient ID: _____ No. of Vials/container: _____

Specimen Collection Information

Date: 8/2/25 Time: 10:30
 Fasting: Yes No Fasting Period: _____
 Collection by: _____
 Urine Volume: _____ ml Hrs _____

Signature of Accessioning Officer(s)

I hereby authorize MolQ Laboratory to use and share with affiliates, my personal information including but not limited to my condition/diagnosis information etc. as may be necessary to perform the test or services and to use the test results for research purposes. I agree to the address of my medical records and specimens for diagnostic and research purposes. The sample used for research will be coded to maintain confidentiality and will be processed as per the rules and regulations specified in applicable by law. In the event of any publication by MolQ Laboratory, Patient's consent is required. For any assistance related to this requisition please contact MolQ Laboratory. In case of any dispute the jurisdiction will be Haryana, Gurgaon, Haryana. The financial liability is comparable to more than MSP of the test requested.

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Dr. Neeraj

HISTO PATHOLOGY REQUISITION SLIP

Date 7/2/25

Name Mrs. Shakuntala w/o. Kishnesh

Age 56 Y Sex female Address Jatewas, Rewari, Bithwana HR

Admission No 9728908770
Mob.

UID - 168140

IPD - 11180



11934409

Specimen cat. - A/B Site

Lipoma

Brief Relevant Clinical History

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.....

