



TEST REQUISITION FORM



Unique Identifier

Unique Identifier: _____

Patient Details

First Name: Prahlad Sharma Last Name: 167236

Age: 63/M 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: _____

Billing Information

Client Name: Pushpanjali Rawat

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/PLCIT	<input type="checkbox"/> PBX 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: _____

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): _____

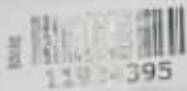
Test Name/Test Code

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

1. _____

2. HPE Small

3. _____

4.  _____

5. _____

6. _____


7. _____

8. _____

9. _____

Instructions to Laboratory/Clinical Information

Instructions to Laboratory/Clinical Information: _____

Information:  Ambient Refrigerated Frozen

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

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 13/2/25 Time: 10:30

Fasting: Yes No Fasting Period: _____ Hr

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 name, birthdate information and any other information necessary to perform the test or service etc. I understand that the information I provide to MolQ Laboratory will be used for the purpose of my medical care and will not be made publicly available. Further, I authorize the use of the following information for immediate research and for future research, if any, and at any time in the future. I agree to the access of my medical records and specimen for diagnostic and research purposes.

Disclaimer: The sample used for research will be marked to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, I understand that I am not entitled to any royalties or other financial benefits. For any further information related to computer/clinical please contact MolQ Laboratory. In case of any dispute the jurisdiction will be Haryana, Gurgaon, Haryana. The limited liability or compensation of any person shall not exceed the amount of the fee paid for the test.

Do not write: If any change in the test result is observed, the patient should consult the doctor for further advice. The patient should not take any self-medication or stop any ongoing treatment without the doctor's advice. The patient should not consume alcohol, tobacco, or any other substance that may affect the test results. The patient should avoid strenuous physical activity and stress. The patient should follow the doctor's instructions regarding the test results and treatment.

Signature: _____ Date: _____ Patient/Client/Doctor's Signature





PUSHPANJALI HOSPITAL



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HISTO PATHOLOGY REQUISITION SLIP

Consultant: Dr. KAMAL SINGH

Date: 12/2/25

Name: M.S. PRAHLAD SHARMA S/o HANUMAN PRASAD

Age: 53 yrs Sex: Male Address: Mohalla, Prapura W-5 Narnaul
M.H.H.R.

UHID-167236, IPD-24-1137 Admission No. 7015354003

cat - A/B



Specimen: Site:

Brief Relevant Clinical History

RE TURBT - chips

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.....





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Patient Name: Mr. PRAHLAD SHARMA UHID No. : 167236 IPD No. : 24-11337
Age / Sex: 63y / M Bed No. : _____ D.O.A. 12/2/25 D.O.S. 12/2/25

OPERATION THEATRE NOTES

Surgeon In-charge : Dr. Kamal Anesthetist : Dr. Mohit
Assistant Surgeon : Dr. Yogesh OT Technician : _____
OT Staff : _____ Type of Anaesthesia : SA
Pre-Operative Diagnosis : kko Ca-Bladder
Post - Operative Diagnosis : _____
Procedure Name : Re-TURBT
Operation Started at : _____ Operation Finished at : _____ Duration : _____
Sponge Count : _____ Whome : _____

Operative Notes : findings :- Resected. margin \bar{e} scar tissue at tumor bed. on ^(U) postero-lateral wall of bladder.

Procedure :- After PND of Parts, LASP, Cystourethroscopy done, above mentioned findings are noted. Deep margins of tumor bed is resected. Complete Hemostasis ensured. TURBT chips retrieved using Ellik's evacuator. 18Fr foley's Catheterization done.

Organ Explored : _____
Specimen Sent for histopathology (if any) : _____
Immediate post-operative condition : Good.

Surgeon's Signature : [Signature]
Date & Time : 12/2/25 (am / pm)