



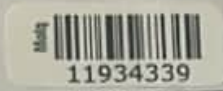
PUSHPANJALI HOSPITAL



(A Unit of Pushpanjali Medicare Pvt. Ltd.)
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 E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC207727

Lab No:

HISTOPATHOLOGY REQUISITION FORM

Patient Name Urmila Devi Referring Doctor Dr. Manoj Yadav Date 15/02/15
 Name _____ Date of Birth 59 Sex: Male / Female
 IPD No _____ Collection Centre _____ Uhid No. 000773 **O.P.D**
 Telephone _____  RCC _____
 (if different)

Site of Specimen: Antrum

Relevant Clinical History:

Gastric pain

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

Type of Specimen:

Large Medium Small

Antral biopsy to Rls N. Pylori

- Miscellaneous
- IHC markers
- Special Stains
- Microphotography

Histopath Slides / Block for review:

Fixation

Adequate
 Inadequate
 Dr. Manoj Yadav
 MBBS, MD (Gold Medalist)
 DNB Gastroenterology
 Reg No. HN 17067
 Pushpanjali Hospital, Rewari

Doctor's Signat



Unique Identifier

TEST REQUISITION FORM

Patient Details

First Name: Urmila Devi Last Name: 0007773
 Age: 51/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 Report

Billing Information

Client Name: Pushpanjali Rawan
 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/FLU/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: _____


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

Send Specimen Information

Ambient Refrigerated Frozen

Contn
 Vial ID Barcode

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 16/2/25 Time: 2:06
 Fasting: Yes No Fasting Period: _____
 Collection by: _____
 Urine Volume: _____ ml Hrs. _____

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 service. Information 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 and at all times in the future. I agree to the access of my medical records and specimen for diagnostic and research purposes.
 The 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 my publication by MolQ Laboratory, Patient information will be confidential. For any test/service related complaint/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 shall be as per MRP of the test requested.

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 any query reach us at contact@molq.in Customer care 9999 778 778; Laboratory 0124-4307906

Patient ID : UHID 000773
Patient Name : URMILA DEVI
Age/Gender : 59Yrs, Female

Visit Date : 15/07/2025
Referred by : Dr. Manoj Yadav
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 visualization.

- Premedication : Xylocaine spray LA
- Esophagus : Diaphragmatic hiatus at 38 cm, pgf at 37 cm, x line at 37 cm
- OG Junction : 37 Crc, Hills grade 1
- Stomach :
 - Fundus : Normal
 - Body : Normal
 - Antrum : Erosive antral gastritis
 - Pylorus : Normal
- Duodenum :
 - D1 : Normal
 - D2 : Normal
- Biopsy : Taken from antrum
- Impression : Erosive antral gastritis, RUT +ve

