



PUSHPANJALI HOSPITAL

(A Unit of Pushpanjali Medicare Pvt. Ltd.)

Rajesh Pilot Chowk, Garhi Bolni Road, Rewari-123401 (Haryana), India

Phone No +91-1274-263300, 260021

E-mail : pushpanjalihospitalrewari@gmail.com, CIN: UB5110DL1987PTC207727



HISTO PATHOLOGY REQUISITION SLIP

Dr Kiran Yadav

Date 18-2-25

Name Mrs Sarmita Yadav Lab Karanpal Yadav

Age 46 Y Sex F Address H No 77P Soami Bihari

UHID = 168809 Admission No. 94682 90146

11498

Specimen Site

Brief Relevant Clr



11934322

Big mass uterus + ex B/c lusc

Brief Operative



11934321

2. Ligame from anterior abd

Any Relevant Special Investigation

CYTOLOGY REQUISITION SLIP

Cytology Papsmear

Clinical Finding and History LMP /

Normal / Post Menoposal / Suspicious Lesson / Other

Site of Sample

Cervix / Post fomix, Lat Vag wall / endo Cervix

Ref. Dr.





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Phone No +91-1274-263300, 260021
E-mail : pushpanjalihospitalrewari@gmail.com, CIN: U85110DL1987PTC207727

Patient Name: Mr. Sanjay UHID No. 168809 IPD No. 12498

Age / Sex: 46 yf Bed No. _____ D.O.A 17-2-25 D.O.S 18-2-25

OPERATION THEATRE NOTES

Surgeon In-charge: Dr. Neeraj Anesthetist: Dr. Mohit

Assistant Surgeon: _____ OT Technician: Rakesh

OT Staff: _____ Type of Anaesthesia: _____

Pre-Operative Diagnosis: LIPOMA OVER (L) UPPER ABDOMINAL ANTERIOR WALL

Post - Operative Diagnosis: _____

Procedure Name: EXCISION DONE

Operation Started at: _____ Operation Finished at: _____ Duration: _____

Sponge Count: _____ Whome: _____

Operative Notes :

OT Pays - Approx. 1.1 cm lipomatous lesion excised from (L) upper anterior abdominal wall from left upper quadrant

Organ Explored: _____

Specimen Sent for histopathology (if any): Lipom

Immediate post-operative condition: _____

Surgeon's Signature: _____

Date & Time: _____ (am / pm)

TEST REQUISITION FORM



Unique Identifier

Test

Molq



11934321

Patient Details

Name: Sunita Dada-2 Last Name: _____

Gender: Male Female

Address: _____

Contact No: _____

ID: _____

Ordered By: _____ Contact No: _____

Maternal Screening -Date of Birth-

Weight: _____ kg Height: _____ inches LMP: _____ Last Ultrasound Report

Payment Information

Name: Pushpanjali Rewari

Address: _____

Amount: _____

Received: _____ Receipt No: _____

Balance /Due: _____

Payment via: Cash Cheque Credit Platform

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/IT | <input type="checkbox"/> FN Aspirate | <input type="checkbox"/> Fluid |
| <input type="checkbox"/> SST | <input type="checkbox"/> Tissue Formatin | <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"/> Seab |
| <input type="checkbox"/> Semen | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Sample Type/Source: _____

Specimen Information (For MolQ use only)

Temperature: Ambient Refrigerated Frozen

Time: _____

Order No: _____ No. of Vials/Container: _____

1 _____ 2 _____

Signature of Accessioning Officer(s)

1 _____
2 HPE Small-2
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Instructions to Laboratory/Clinic

Send Specimen Information

1 Molq Ambient



11934321

Container

Total No. of Vials/Container: _____

Specimen Collection Information

Date: 19/2/25

Fasting: Yes No

Collection by: _____

Urine Volume: _____

