DIAGNOSTICA SPAN
when quality matters...

Test Requisition Form

Executive Name: Sahil
Signature :

Pick-up Date: 28/1/23
Pick-up Time: _____ AM / PM

For Lab use only
Specimen Barcode

PATIENT INFORMATION:

*** PATIENT'S NAME (Block Letters: First Name Mandatory)

Maya Rathaur

(First Name) (Middle Name) (Last Name)

Patient's Address: _____

Phone No.: _____

Email ID: _____

***Date of Birth: _____ ***Gender ☐ Male ☐ ~~Female~~

Age: 43 Yrs _____ Months _____ Days

Height: _____ cms Weight: _____ Kgs

BILL TO:

***Client Code:

Name Address _____

Phone No.: _____

Email ID: _____

*** Referring Doctor:

Doctor's Name: R. K Cots

Phone No. : _____ City _____

Email ID: _____

Test Requirements: Please refer to the Directory of services for correct Test Code

***Test Code	***Test Name
	Histopath

Specimen Information

Date & Time of sample Collection: Time AM / PM

Signature:

For Repeat / Add on Test / Follow-up Patient

Old Lab Accession No.:

Essential Clinical Information
(Please fill in whatever is relevant) 23586675

1) Provisional diagnosis: _____
2) H/o Medication: Yes / No
if yes, Name & Dose: _____
3) Status of Medication: Ongoing / Terminated
if ongoing, Duration: _____
if terminated, When: _____
4) LMP (where applicable): _____
5) Fasting Period _____
6) 24 Hour Urine Volume _____
7) For Genome studies attach detailed history
8) Attach other relevant information

*** Temperature Sent	*** Temperature Recd.
zen:	Frozen:
rigerated:	Refrigerated:
ient:	Ambient:

Received in Diagnostica Span:

Date & Time: _____
Courier Barcode No. _____
No. of Samples received: _____
Any Discrepancy noted (if yes • record details): _____

Initials of Sample Receiving Staff: _

*****Specimen Type (with Qty)**

um	Bactec Bottle*
Nood ACD	Swab*
ood EDTA	Pus*
ood Flouride	Body Fluid*
: EDTA/CIT/FL	BAL
d Heparin	CSF
d Sodium Citrate	Sputum (1st/ 2nd/ 3rd)
	Tissue*
ndom/ 1st Morning)	Parafin Block*
Hrs.)	Filter Paper
/ 2nd/ 3rd)	Bone Marrow
s*	

ype / Site of *Sample Collection*

: After completion of the ordered tests, the remaining sample may be stored and used for research in medical sciences.
to receive information or to be contacted through mail, telecommunication, electronic & personal means from Diagnostica Span Labs and p companies, time to time.

I don't agree ☐

Thumb impression of *patient*

Signature of Requisitioner

Date:

t is mandatory to provide all the requested information to enable accurate and timely reporting.

*** **Mandatory fields**

माहेर हॉस्पिटल

पुणे-सोलापूर रोड, राजर्षी बँकेच्या पाठीमागे, उरूळी कांचन, ता. हवेली, जि. पुणे - ४१२२०२, मो.: ९६५७७५६०४१ / ८६०५८४८४७६

डॉ. टि.वाय. मोटे
M.B.B.S., M.S.(OBGY)
स्त्रीरोग व प्रसुतीतज्ञ
Reg. 91055

Hospital Reg No. 248

डॉ.सौ. राजश्री टि. मोटे
B.A.M.S.
Reg. 29398A

दि. 28/01/2023.

℞

Maya Ps

To

Pathologist

Sending herewith following specimen for Histopathological examination.

pt's name:- Mrs. Maya Prakash Ransur.

Age- 43 yrs.

Specimen- Uterus c Cx c Bilateral tubes c Rt ovary.

Clinical hist- 43 yrs g1p1L1A1 c Adenomyosis c endometrial polyp.

Surgery - Total Abdominal hysterectomy c Rt L salpingo oophorectomy c Rt cystorectomy.

Thanks.

Dr.T.Y.Mote
M.S.(OBGY)
Reg.NO. 91055
Obstetrician & Gynaecologist

पुढील तपासणीची तारीख : / /२० परत येताना हा पेपर सोबत आणावा.

No substitute