Expertise. Empowering you.

TEST REQUISITION FORM

Center Code: Rajlakshmi

PATIENT'S NAME(Block Letters) MRS. PRIYANKA - YADAV	Client Code
Patient's Address	Name & Address Shri Raj-laxmi drugs
Ph..... Alternate No	
Date of Birth ..... Male / Female ✓	**REFERING DOCTOR**
Age 33. Fasting / Nonfasting	Doctor's Name DR. DIPPY - AGGARWAL.
Height ..... FT ..... IN, Weight ..... Kg	Phone No. ..... City .....

Test Code	Test Description	Test Amount	SPECIMEN INFORMATE ID
	Triple - Marker test.		
			Clint Name : .....
	S-24285121		
			Drawn Date : .....
			Time Drawn : .....
	TOTAL		

Clinical History :-
Date of Birth. 07.05.1991
***

TEMPERATURE SENT	TEMPERATURE RECD.
Frozen (0-2° Celsius)	Frozen (0-2° Celsius)
Gel Pack (2-8° Celsius)	Gel Pack (2-8° Celsius)
Temp (18° - 22° Celsius)	Gel Pack (2-8° Celsius)

Other information

TEST REQUIREMENTS : Please refer to the AHLL Reference Guide for Correct test Code / or Name & Specimen Type.

SPECIMEN TYPE

- ❑ Serum
- ❑ Plasma.....
- ❑ W. Blood EDTA
- ❑ W. Blood Fluoride
- ❑ W. Blood Heparin
- ❑ W. Blood Sodium Citrate
- ❑ W. Blood ACD
- ❑ Pus
- ❑ Fluid
- ❑ Sputum
- ❑ Filter Paper
- ❑ Bone Marrow
- ❑ CSF
- ❑ Tissue-Small/Medium
- ❑ Slide (H & E)
- ❑ Urine 1st Morn.
- ❑ Random Urine
- ❑ 24hrs Urine
- ❑ BAL
- ❑ Stool
- ❑ Swab
- ❑ Others

Paid

Patient Signature (Date &Time)	Phlebotomist Signature (Date &Time)	Requested by CC/PUP/Hospital/Doctor: (Date &Time)

1) Constipation — Movicol sachet (2)

2/6/23

SHREE RAJLAKSHMI DRUGS