MANUSHREE IMAGING CENTRE

Dr. Mayank Ujjaliya
MD Radiodiagnosis

Ex. Consultant Radiologist
Bansal Hospital, Bhopal
Ex. SR. PGIMER Chandigarh
Ex. Consultant Star Hospital, Ahmedabad

Pt. Name:	MRS. NEVIDA JAIN	Age/Sex:	35 Years / Female
Ref. By:	DR. SAPNA JAIN	Date:	19/06/2023

USG OBSTETRICS NTNB/EARLY ANOMALY SCAN

LMP- 15.03.2023 **GA LMP- 13w5d.**

Findings:

Single intrauterine gestation seen.

Changing lie and presentation.

Placenta –Posterior.

CRL- 68 mm corresponding to 13w1d.

Fetal heart rate 170 b/min.

Internal os is closed.

First trimester anomaly scan

Nasal bone – present

Nuchal translucency (NT) measures – 1.0 mm (normal).

Normal ductus venosus waveform with positive 'a' wave.

Right uterine artery PI-1.27. Left uterine artery PI-2.72. Mean PI-1.99 (83rd centile-normal).

IMPRESSION:Ultrasound findings are suggestive of single live intra-uterine pregnancy. The approximate gestational age is around 13w1d.

EDD by USG-24.12.2023

*I, **Dr.Mayank Ujjaliya, MD** declare that while conducting USG, I have neither declared nor disclosed the sex of her fetus to anybody in any manner.*

DR. MAYANK UJJALIYA
MD (MP-16150)

Shop No. 4 CI Square, Kolar Road, Bhopal

Ph.: 0755-3597661, 9303614620

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Timing 9:00 am to 9:00 pm

DIAGNOSTICA SPAN

Test Requisition Form

Executive Name: _____
Signature: _____

Pick up Date: 20/6/23
Pick up Time: _____ AM / PM

Weight - 68
Height - 5.4
DoB - 10/11/1986

For Lab use only
Specimen Barcode

PATIENT INFORMATION:

BILL TO: Dev Pathology

*** **PATIENT'S NAME** (Block Letters: First Name Mandatory)
MrS Nevida jain
(First Name) (Middle Name) (Last Name)

Patient's Address: _____

Phone No.: _____

Email ID: _____

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

Age: 35 Yrs 4 Months _____ Days

Height: _____ cms Weight: _____ Kgs

***Client Code:
Name, Address:

Phone No: _____

Email ID: _____

*** **Referring Doctor:**

Doctor's Name: _____

Phone No: _____ City: _____

Email ID: _____

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

***Test Code	***Test Name
	Double
	May 12 23

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)

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.
Frozen:	Frozen:
Refrigerated:	Refrigerated:
Ambient:	Ambient:

***Specimen Type (with Qty)

Serum	Bactec Bottle*
W. Blood ACD	Swab*
W. Blood EDTA	Pus*
W. Blood Flouride	Body Fluid*
Plasma: EDTA/CIT/FL	BAL
W. Blood Heparin	CSF
W. Blood Sodium Citrate	Sputum (1st/ 2nd/ 3rd)
Slide*	Tissue*
Urine (Random/ 1st Morning)	Parafin Block*
Urine (24 Hrs.)	Filter Paper
Stool (1st/ 2nd/ 3rd)	Bone Marrow
Any Others*	

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: _____

***Mention Type / Site of Sample Collection**

Please Note: After completion of the ordered tests, the remaining sample may be stored and used for research in medical sciences.

I/ We agree to receive information or to be contacted through mail, telecommunication, electronic & personal means from Diagnostica Span Labs and related group companies, time to time.

I don't agree ☐

Signature / Thumb impression of patient

Date:

Signature of Requisitioner

Date:

*** Mandatory fiel

IMPORTANT : It is mandatory to provide all the requested information to enable accurate and timely reporting