Dr Lal PathLabs

LPL LAB NO.

AFFIX BAR

TEST REQUISITION FORM

PATIENT INFORMATION : **CORP. :** **BILL TO :**

PATIENT'S NAME (Block Letters)

Patient's Address: .....

.....

UID : .....

Phone No. : .....

Date of Birth : ..... ☐Male ☐Female

Age : ..... Years ..... Months.....Days

Height : .....Ft.....cm Weight : ..... Kg.

C. C. : ☐☐☐☐☐

Name & Address:

R.C. C. : ☐☐☐☐☐

Name & Address:

REFERRING DOCTOR:

Doctor's Name : .....

Phone No. .....City.....

Test Code	Test Description	Test Amount
	TOTAL	

SPECIMEN INFORMATION

Hospital / CC / PUP .....

Drawn Date : .....

Time Drawn : .....

Discount Percent	Gross Amount Payable	
	Less Discount (if any)	
Discount Details	Net Amount Payable	
	Less Amount Paid	
	Balance Due	

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

TEST REQUIREMENTS : Please refer to the LPL Reference Guide for correct test code / Name / specimen type

FOR REPEAT / FOLLOW – UP PATIENTS

Old LPL Lab No. .....

SPECIMEN TYPE

	Qty.		Qty.
☐ Serum		☐ CSF	
☐ Plasma EDTA/FL/ CIT/ACD		☐ Tissue-Small/Medium*	
☐ FN Aspirate		☐ Tissue-Large*	
☐ W.Blood ACD		☐ Parafin Block*	
☐ W.Blood EDTA		☐ Smear	
☐ W. Blood Fluoride		☐ Slide (H & E)*	
☐ W. Blood Heparin		☐ Urine 1st Morn. / Random Urine / 24 hrs Urine	
☐ W. Blood Sodium Citrate		☐ BAL	
☐ Pus		☐ Stool	
☐ Fluid		☐ Swab*	
☐ Sputum		☐ Others*	
☐ Filter Paper			
☐ Bone Marrow			

☐ ***Mention Type / Site of Collection**

☐ **TICK SAMPLE WHICH EVER IS APPLICABLE.**

ESSENTIAL CLINICAL INFORMATION

(Please fill in whatever is relevant)

1) Provisional diagnosis : .....
2) H/o Medication : Yes / No
3) If yes, Name: .....
4) Status of Medication : Ongoing / Terminated
5) If ongoing, Duration: .....
6) If terminated, When: .....
7) Fasting Period .....
8) 24 Hour Urine Volume .....
9) For Histopathlogy / IHC, Attach Detailed History
10) LMP (where applicable) .....
11) Diabetes Status: Yes / No
12) Gestation Single / Twin
13) Attach other relevant information .....

Signature / Thumb impression of patient *

Date :

Signature of CC / PUP / Hospital

Date :

* **NOTE :** 1.) It is mandatory to provide all the requested information to enable accurate and timely reporting.
2.) Consent is hereby given to use my sample for Quality Assurance & Research purposes if needed.