



Name of Hospital .....

Name of Doctor .....

Telephone Number .....

Name of Patient ..... Age ..... Sex .....

Hospital Registration Number ..... Telephone Number .....

Health Insurance Number ..... Insurer .....

Clinical Details : ..... Para ..... LMP .....

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X-Ray/Ultrasound/CT/MRI : .....

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*Clinical Diagnosis* .....

Previous Histology/Cytology: Lab ID .....

Diagnosis .....

Nature of specimen .....

For Laboratory Use Only.

Investigation Required:

Histology Site taken

Date received .....

Cytology Site taken

Time .....

FNAC: Breast/ Thyroid/ Salivary Gland/ Soft tissue .....

Condition of sample .....

Other: .....

Received by: .....

Date Taken ..... Time: .....