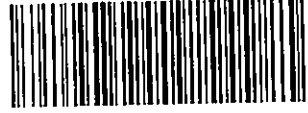


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The accession number is the Reference Number for communication with BAVYA

BHSPL - UHS - KPM



1

BHSPL318430

RETURN THIS PAGE WITH SAMPLES

**LABORATORY REQUISITION FORM**

**Patient Demographics:**

Name	DOB	Age	Gender	NCD Listed Patient
M. Rhojushmi	1976	49	female	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>

**VITALS**

Height Inches	Weight Kgs	Blood Pressure		HR	Temp	SpO2	Waist Inches	Social Behaviour	
		Systole	Diastole					Smoking	Drinking
154	52	110	70	62	98	96	38	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>

**Collection Details**

<table border="1"> <tr><th>Day</th><th>Month</th><th>Year</th></tr> <tr><td>05</td><td>1</td><td>2025</td></tr> </table>			Day	Month	Year	05	1	2025	<table border="1"> <tr><th>Collection Time</th></tr> <tr><td>7:25 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/></td></tr> </table>			Collection Time	7:25 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	<table border="1"> <tr><th>Collection Location</th></tr> <tr><td>Village: Mananketa</td></tr> <tr><td>Mandal: Sankarapur</td></tr> </table>			Collection Location	Village: Mananketa	Mandal: Sankarapur
Day	Month	Year																	
05	1	2025																	
Collection Time																			
7:25 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>																			
Collection Location																			
Village: Mananketa																			
Mandal: Sankarapur																			

(Eg: 01 | 10 | 2025)

(Eg: 07:15 AM)

Patient fasted at least 10 hrs? Y  N

**This section to be completed by SITE PERSONNEL ONLY**

Requisition Completed by	<input type="text" value="G&amp;"/>	# Team	<input type="text" value="29"/>
Phone Number	<input type="text" value="970482664"/>		

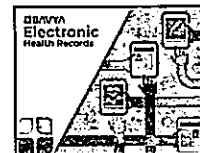
**For Sample Submission HUB use only**

Verifier Name & Emp ID	Tube Count	Validation (sample accepted)	Validator Comments
J. Rajitha	1 <input checked="" type="checkbox"/> 2 <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	good

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PATIENT DETAILS



First Name : M.

Last Name : Bhudakshmi

Your Email : \_\_\_\_\_

Phone Number : 9881591701

Aadhaar Number : 5690 4220 5708

ABHA Health ID Number : 7386 2075 337779

Gender :  Male  Female  Other

Marital Status : married

Date of Birth : 

			1	1	9	2	6
--	--	--	---	---	---	---	---

 49

No of Children : 4

Address : Nanjampeta

CONSENT FOR AUTHENTICATION :

I hereby state that I have no objection to authenticating myself with the Aadhaar-based authentication/ ABHA Health ID systems and I consent to providing my Aadhaar number and/or One Time Pin (OTP) for Aadhaar-based authentication to access my personal Electronic Health Records with Bavya Health Services. I understand that the OTP I provide for authentication will be used solely to verify my identity through the Aadhaar-based authentication / ABHA Health ID systems for that specific transaction and for no other purposes. I also understand that Bavya Health Services will ensure the security and confidentiality of the personal identity data I provide for Aadhaar-based authentication.

Signature/Thumb Impression :

Name : M. Bhudakshmi