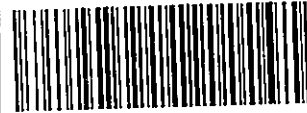




The accession number is the Reference Number for communication with BAVYA

BHSPL-UHS-KPM



5

BHSPL337221

RETURN THIS PAGE WITH SAMPLES

### LABORATORY REQUISITION FORM

#### Patient Demographics:

Name	DOB	Age	Gender	NCD Listed Patient
Mayjaneeth	1987	38	M	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
160	54	120	80	76	98	97	30	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>2</td><td>1</td><td>1 2025</td></tr> </table>			Day	Month	Year	2	1	1 2025	<table border="1"> <tr><th colspan="5">Collection Time</th></tr> <tr><td>0</td><td>7</td><td>3</td><td>0</td><td>AM <input checked="" type="checkbox"/> PM <input type="checkbox"/></td></tr> </table>			Collection Time					0	7	3	0	AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	<table border="1"> <tr><th colspan="2">Collection Location</th></tr> <tr><td>Village</td><td>Jelligaripalli</td></tr> <tr><td>Mandal</td><td>Saulipuram</td></tr> </table>		Collection Location		Village	Jelligaripalli	Mandal	Saulipuram
Day	Month	Year																											
2	1	1 2025																											
Collection Time																													
0	7	3	0	AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>																									
Collection Location																													
Village	Jelligaripalli																												
Mandal	Saulipuram																												
(Eg: 01   10   2025)			(Eg: 07:15 AM)																										
Patient fasted at least 10 hrs?					Y <input checked="" type="checkbox"/> N <input type="checkbox"/>																								

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

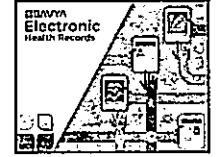
Requisition Completed by	C. Vikas	# Team	4351
Phone Number	7098165138		

#### For Sample Submission HUB use only

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



PATIENT DETAILS



First Name : Manjunath Age: 38y

Last Name : \_\_\_\_\_

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

Phone Number : 8328497523

Aadhaar Number : 6108 5886 0288

ABHA Health ID Number : 17-4641-0625-5374

Gender :  Male  Female  Other

Marital Status : \_\_\_\_\_

Date of Birth : 

--	--	--	--	--	--

1987

No of Children : 2

Address : Jalliganipalli

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.

*Handwritten signature*

Signature/Thumb Impression :

Name : Manjunath