



The accession number is the Reference Number for communication with BAVYA

BHSPL-UHS-KPM



4

BHSPL312455

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5/17/25

### LABORATORY REQUISITION FORM

**Patient Demographics:**

| Name    | DOB       | Age | Gender | NCD Listed Patient  |
|---------|-----------|-----|--------|---|
| V. GOPi | 18-4-1999 | 26  | m      | Y <input type="checkbox"/><br>N <input checked="" type="checkbox"/> |

**VITALS**

| Height<br>Inches | Weight<br>Kgs | Blood Pressure |          | HR | Temp   | SpO2 | Waist<br>Inches | Social Behaviour  |   |
|------------------|---------------|----------------|----------|----|--------|------|-----------------|---|---|
|                  |               | Systole        | Diastole |    |        |      |                 | Smoking   | Drinking  |
| 156<br>cm        | 74<br>kg      | 110            | 70       | 82 | 90.6 F | 95%  | 32              | Y <input type="checkbox"/><br>N <input checked="" type="checkbox"/> | Y <input type="checkbox"/><br>N <input checked="" type="checkbox"/> |

**Collection Details**

|                      |       |      |                 |  |                     |                |
|----------------------|-------|------|-----------------|--|---------------------|----------------|
| Day                  | Month | Year | Collection Time |  | Collection Location |                |
| 05                   | 11    | 2025 | 7:51            | AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> | Village             | Chinnaganballi |
| (Eg: 01   10   2025) |       |      | (Eg: 07:15 AM)  |  | Mandal              | Shanthipuram   |

Patient fasted at least 10 hrs? Y  N

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

Requisition Completed by M. L. Dayana # Team 47

Phone Number 9014793082

### For Sample Submission HUB use only

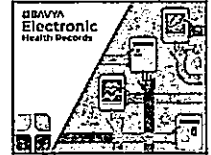
| Verifier Name & Emp ID | Tube Count   | Validation (sample accepted)  | Validator Comments |
|------------------------|--|---|--------------------|
| J. Peethu              | 1 <input checked="" type="checkbox"/><br>2 <input checked="" type="checkbox"/> | Y <input checked="" type="checkbox"/><br>N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

Chinnagandlapalli - 47 - 6

5/11/25



PATIENT DETAILS



First Name : V. GOPI

Last Name : -

Your Email : -

Phone Number : 8549008065

Aadhaar Number : 9070 4413 3821

ABHA Health ID Number : 16-1824-1708-3100

Gender :  Male  Female  Other

Marital Status : married

Date of Birth : 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1 | 8 | 0 | 4 | 1 | 9 | 9 | 9 |
|---|---|---|---|---|---|---|---|

No of Children : 2

Address : Chinnagandlapalli

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.

V. Gopi

Signature/Thumb Impression :

Name : V. Gopi