

KHAPOLUGPTL68
71m

AC01.0002158244, Mr.MAGUNTA SREENIVASLU, 71Y - OM - 0 /BARCODE NO.



OU00110847,
WHOLE BLOOD EDTA - P00001
DAKNOPV278006, 31 - Dec - 24 12:22 PM

TEST REQUISITION FORM

Center Code:

PATIENT'S NAME(Block Letters)

Mr. magunta sreeniva -
- salu Reddy

Client Code

Patient's Address

Name & Address

Apollo Neaghosdeer,

Ph..... Alternate No

Date of Birth Male Female

REFERRING DOCTOR

Age 31 Fasting Nonfasting

Doctor's Name Selv

Height FT IN, Weight Kg

Phone No. City

Test Code	Test Description	Test Amount	SPECIMEN INFORMATE ID
	gene panelx total		Clint Name :
			Drawn Date : 20/12/24
			Time Drawn : 7:34 pm
	TOTAL		

Clinical History :-

TEMPERATURE SENT	TEMPERATURE RECD.
Frozen (0-2° Celsius)	Frozen (0-2° Celsius)
Gel Pack (2-8° Celsius)	Gel Pack (2-8° Celsius)
Temp (18° - 22° Celsius)	Gel Pack (2-8° Celsius)

Other information

TEST REQUIREMENTS : Please refer to the AHLL Reference Guide for Correct test Code / or Name & Specimen Type.

SPECIMEN TYPE

- | | | | |
|---|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Serum | <input type="checkbox"/> W. Blood ACD | <input type="checkbox"/> CSF | <input type="checkbox"/> BAL |
| <input type="checkbox"/> Plasma..... | <input type="checkbox"/> Pus | <input type="checkbox"/> Tissue-Small/Medium | <input type="checkbox"/> Stool |
| <input checked="" type="checkbox"/> W. Blood EDTA | <input type="checkbox"/> Fluid | <input type="checkbox"/> Slide (H & E) | <input type="checkbox"/> Swab |
| <input type="checkbox"/> W. Blood Fluoride | <input type="checkbox"/> Sputum | <input type="checkbox"/> Urine 1st Morn. | <input type="checkbox"/> Others |
| <input type="checkbox"/> W. Blood Heparin | <input type="checkbox"/> Filter Paper | <input type="checkbox"/> Random Urine | |
| <input type="checkbox"/> W. Blood Sodium Citrate | <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> 24hrs Urine | |

Patient Signature
(Date &Time)

Phlebotomist Signature
(Date &Time)

Requested by CC/PUP/Hospital/Doctor:
(Date &Time)

Physical Examination

- a. Blood Pressure: 120/80 mmHg
- b. Pulse Rate: 68/min
- c. Height: 66
- d. Weight: 76,
- e. BMI: _____

Blood Work

Mandatory Tests		
1	Complete Blood Count	<input checked="" type="checkbox"/>
2	Thyroid Profile	<input checked="" type="checkbox"/>
3	HbA1C	<input checked="" type="checkbox"/>
4	Liver Function Test	<input checked="" type="checkbox"/>
5	Kidney Function Test	<input checked="" type="checkbox"/>
6	Lipid Profile	<input checked="" type="checkbox"/>

Family History

Condition	If Yes, which member of the Family			
Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Suicide Attempts	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature Myocardial Infarction	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Death	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consanguineous Marriage	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cerebrovascular Accident	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Father <input checked="" type="checkbox"/>	Mother <input type="checkbox"/>
Seizures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Father <input type="checkbox"/>	Mother <input type="checkbox"/>
Hearing/Speech Problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sibling <input type="checkbox"/>	Other <input type="checkbox"/>
Alcohol Abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Cirrhosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Connective Tissue Diseases	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin

- | | |
|------------------|-------------------------------------|
| Itching | <input checked="" type="checkbox"/> |
| Persistent Rash | <input checked="" type="checkbox"/> |
| New Skin Lesions | <input checked="" type="checkbox"/> |
| Hair Loss | <input checked="" type="checkbox"/> |
| Excessive Hair | <input checked="" type="checkbox"/> |

Neurologic

- | | |
|-------------------------|-------------------------------------|
| Frequent Headaches | <input checked="" type="checkbox"/> |
| Double Vision | <input checked="" type="checkbox"/> |
| Weakness | <input checked="" type="checkbox"/> |
| Change in Sensation | <input checked="" type="checkbox"/> |
| Dizziness | <input checked="" type="checkbox"/> |
| Tremors | <input checked="" type="checkbox"/> |
| Episodes of Vision Loss | <input checked="" type="checkbox"/> |

Endocrine

- | | |
|-----------------------------|-------------------------------------|
| Intolerance to Heat or Cold | <input checked="" type="checkbox"/> |
| Frequent Hunger or Thirst | <input checked="" type="checkbox"/> |
| Changes in Sex Drive | <input checked="" type="checkbox"/> |

Allergic/Immunologic

- | | |
|------------------------|-------------------------------------|
| Food Allergies | <input checked="" type="checkbox"/> |
| Seasonal Allergies | <input checked="" type="checkbox"/> |
| Itching Eyes/ Sneezing | <input checked="" type="checkbox"/> |
| Frequent Infections | <input checked="" type="checkbox"/> |

Patient Intake Form

Name:	MR. MAGUNTA SREENIVASALU
Address	Age: 71 Y/M AHC No AOC AH6 109
Referred Doctor:	Date 26/12/2024 12 46 57 PM
Sample coordinator	UHID: AC01 0002158244



Current Complaints

Complaint 1: _____

- a. Onset
- b. Duration

Complaint 2: _____

- a. Onset
- b. Duration

Complaint 3: _____

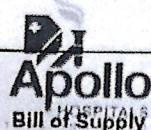
- a. Onset
- b. Duration

Reason for Genetic Testing?

Why do you want to do this genetic testing

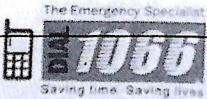
- | | | |
|----|--|---|
| 1 | I want to know if there is any genetic cause for my Medical Condition. | <input checked="" type="checkbox"/> |
| 2 | I want to know if there is any genetic cause for a symptom I have been having since a long time. | <input checked="" type="checkbox"/> |
| 3 | My family or close relatives are having history of chronic disease. | <input checked="" type="checkbox"/> N/A |
| 4 | There is a history of cancer in me/ history of cancer in the family. | <input checked="" type="checkbox"/> |
| 5 | Have a history of genetic disease in the immediate family or close relatives. | <input checked="" type="checkbox"/> |
| 6 | I want to know the future risks and possibilities regarding my health. | <input checked="" type="checkbox"/> |
| 7 | I want to check if we are carriers for any genetic illness. | <input checked="" type="checkbox"/> |
| 8 | I want to know treatment plans based on genetics for our illness. | <input checked="" type="checkbox"/> |
| 9 | I have received an abnormal prenatal screening test or Amniocentesis. | <input checked="" type="checkbox"/> |
| 10 | I want to do it because my other family members have taken genetic testing. | <input checked="" type="checkbox"/> |
| 11 | I want to know my Genetic makeup. | <input checked="" type="checkbox"/> |

GSTIN: 33AAC5443N3ZN



OP Cash Bill -

Reference No:



Name : Mr. MAGUNTA SREENIVASALU REDDY	Age: 71Yr 3Mth 10Days Sex: Male	UHID: AC01.0002158244
Father Name : RAGHAVA REDDY		
Address : NO 18 SUBBARAO AVENUE COLLEGE ROAD Chennai Tamil Nadu India 600006 , CellNo:91-9840479937	OP Number: AOCAH6109 	
Doctor's Name : Dr. Sheela Nagusah		
Speciality : GENERAL MEDICINE	Bill No : AOC-OCS-18849	
Payer Name : APOLLO PROHEALTH ZEN CLINICALLY INDICATIVE TESTS AGREEMENT	Date : 26-Dec-24	Time : 15:33:27
Ref No : --		
Authorization No : CIR/2025/121512/1462314		
Employer Name : APOLLO HOSPITALS		

Bill Amount: ` 0.00

FOR APOLLO HOSPITALS

Amount in words: ` Zero Only

S.No	Aliascode	Service Type\Service Name	Department	Qty	Ref Tariff	Dis(%)	Amount(INR)
Investigations (999311)							
1	954	BLOOD GROUPING AND TYPING (ABO and Rh)	Blood Bank - 2 Services	1	0.00	0.00	0.00
2	1738	PURE TONE AUDIOMETRY	Ear Nose and Throat	1	0.00	0.00	0.00
3	6279	RA FACTOR	Microbiology	1	1,500.00	0.00	1,500.00
4	14690	CORTISOL - SERUM (AM)	BioChemistry	1	3,300.00	0.00	3,300.00
5	16678	AIDS TEST / HIV	Microbiology	1	3,100.00	0.00	3,100.00
6	49073	ANTI HCV	Microbiology	1	0.00	0.00	0.00
7	51757	UROFLOW STUDY	Urology	1	0.00	0.00	0.00
8	82157	FIBRO SCAN	Gastroenterology	1	0.00	0.00	0.00
9	1120418	640 SLICE CT CORONARY ANGIO	C T Scan Radiology	1	0.00	0.00	0.00
10	3051765	Low dose CT with Calcium Scoring	C T Scan Radiology	1	0.00	0.00	0.00
11	0	VITAMIN B2 (RIBOFLAVIN)	BioChemistry	1	0.00	0.00	0.00
12	0	VITAMIN B6	BioChemistry	1	0.00	0.00	0.00
Sub Total							7,900.00

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Keep the records carefully and bring them along during your next visit to our hospital

For enquires, appointments & Telemedicine consultations contact: 044 - 40401066

Registered Office : APOLLO HOSPITALS ENTERPRISE LIMITED No.19, Bishop Gardens,Raja Annamalaiapuram, Chennai- 600 028, CIN-L85110TN1979PLC008035
 APOLLO HOSPITALS : 21, Greams Lane, Off Greams Road, Chennai 600 006. Phone: 044 2829 3333, 2829 0200 Fax: 044 2829 4429
 e-mail: enquiry@apollohospitals.com Website: www.apollohospitals.com

Past Medical History

Asthma	<input checked="" type="checkbox"/>	Peptic Ulcer disease	<input checked="" type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/>	Inflammatory bowel disease	<input checked="" type="checkbox"/>
High Cholesterol	<input checked="" type="checkbox"/>	Frequent Constipation	<input checked="" type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	Frequent Diarrhea	<input checked="" type="checkbox"/>
Coronary Artery Disease (70+)	<input checked="" type="checkbox"/>	Seizures	<input checked="" type="checkbox"/>
Cerebrovascular Accidents/ Stroke	<input checked="" type="checkbox"/>	Migraines	<input checked="" type="checkbox"/>
Myocardial Infarction/ Heart Attack	<input checked="" type="checkbox"/>	Depression	<input checked="" type="checkbox"/>
Hyperthyroidism	<input checked="" type="checkbox"/>	Anemia	<input checked="" type="checkbox"/>
Hypothyroidism	<input checked="" type="checkbox"/>	Cancer	<input checked="" type="checkbox"/>
Kidney Stones	<input checked="" type="checkbox"/>	Arthritis	<input checked="" type="checkbox"/>
Frequent Sinus Infections	<input checked="" type="checkbox"/>	Psoriasis/Skin Conditions	<input checked="" type="checkbox"/>
Others	<input checked="" type="checkbox"/>		

Past Surgical History

Appendectomy	<input checked="" type="checkbox"/>	Joint Replacements	<input checked="" type="checkbox"/>
Tonsillectomy	<input checked="" type="checkbox"/>	Cardiac Stent Placements	<input checked="" type="checkbox"/>
Coronary Artery Bypass Grafting (CABG)	<input checked="" type="checkbox"/>	Hysterectomy	<input checked="" type="checkbox"/>
Splenectomy	<input checked="" type="checkbox"/>	Oophorectomy	<input checked="" type="checkbox"/>
Bariatric Surgery	<input checked="" type="checkbox"/>	Cholecystectomy	<input checked="" type="checkbox"/>
Others	<input checked="" type="checkbox"/>		

Mental Health History (Subjective)

- Do you face any difficulty concentrating on your work? Yes Sometimes No
- Have you lost much sleep/difficulty sleeping? Yes Sometimes No
- Do you feel you are not playing a useful part in your work? Yes Sometimes No
- Do you feel you are under constant stress? Yes Sometimes No
- Do you feel you could not overcome difficulties? Yes Sometimes No
- Do you feel unhappy or depressed most days of the week? Yes Sometimes No
- Do you feel you are losing confidence? Yes Sometimes No
- Do you have any stressors in family or professional life more than ordinary? Yes Sometimes No
- Do you consider yourself an anxious person? Yes Sometimes No

Details if Yes for any question above

Sexual History

✓)P

Women	
Menstrual Cycles	Regular <input type="checkbox"/> Irregular <input type="checkbox"/>
History of Infertility	Yes <input type="checkbox"/> No <input type="checkbox"/>

Men	
Erectile Dysfunction	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Personal History/Health

Do You Drink Alcohol?	Yes	<input checked="" type="checkbox"/>	Previous Drinker	<input type="checkbox"/>	Never	<input checked="" type="checkbox"/>	
How Many Drinks Per Week?	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	More Than 3
Do You Smoke Cigarettes	Yes	<input type="checkbox"/>	Previous Smoker	<input type="checkbox"/>	Never Smoker	<input checked="" type="checkbox"/>	
If Yes, How Many Packets of Cigarettes Per Day?	Less than 1	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	More Than 2
What is your wake up time	Before 6 am	<input checked="" type="checkbox"/>	After 6 am	<input type="checkbox"/>			
What is your go to bed time	Before 8 pm	<input type="checkbox"/>	After 8 pm	<input checked="" type="checkbox"/>			
Do You Workout	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>			
If Yes, How Many Times Per Week?	Less than 4	<input type="checkbox"/>	More than 4	<input checked="" type="checkbox"/>			
Any participation in active sport when young?	Yes	<input checked="" type="checkbox"/>	Never	<input type="checkbox"/>			

Diet

How many meals/day	Less than 3	<input type="checkbox"/>	3	<input checked="" type="checkbox"/>	More than 3	<input type="checkbox"/>	
How many times do you eat processed foods per week(Chips,Fried Items, Fast Food)?	None	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	More Than 2
How many times do you eat outside food?	None	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	More Than 2
How many times do you have soft/carbonated drinks per Week?	None	<input type="checkbox"/>	1	<input checked="" type="checkbox"/>	2	<input type="checkbox"/>	More Than 2

Current and Past Medications

Please name the list of Medications being used currently

	Name of the Medicine	Dose	Frequency
1			
2			
3			
4			

Review of Systems

Constitutional		ENT	
Lack of Energy	<input checked="" type="checkbox"/>	Sinus Problem	<input checked="" type="checkbox"/>
Unexplained Weight Loss/Gain	<input checked="" type="checkbox"/>	Difficulty in Hearing	<input checked="" type="checkbox"/>
Loss of Appetite	<input checked="" type="checkbox"/>	Ringing in Ears	<input checked="" type="checkbox"/>
Fevers	<input checked="" type="checkbox"/>		
Night Sweats	<input checked="" type="checkbox"/>		
Cardiovascular		Respiratory	
Heart Racing/Palpitations	<input checked="" type="checkbox"/>	Shortness Of Breath	<input checked="" type="checkbox"/>
Chest Pain	<input checked="" type="checkbox"/>	Prolonged Cough	<input checked="" type="checkbox"/>
Swelling of legs/feet	<input checked="" type="checkbox"/>	Wheezing	<input checked="" type="checkbox"/>
Pain in calf while walking	<input checked="" type="checkbox"/>		
GU		Gastrointestinal	
Painful Urination	<input checked="" type="checkbox"/>	Heartburn	<input checked="" type="checkbox"/>
Frequent Urination	<input checked="" type="checkbox"/>	Constipation	<input checked="" type="checkbox"/>
Prostate Problems	<input checked="" type="checkbox"/>	Intolerance to certain food	<input checked="" type="checkbox"/>
Kidney Stones	<input checked="" type="checkbox"/>	Diarrhea/ Loose Stools	<input checked="" type="checkbox"/>
		Difficulty in Swallowing	<input checked="" type="checkbox"/>
		Musculoskeletal	
		Joint Pains	<input checked="" type="checkbox"/>
		Aching Muscles	<input checked="" type="checkbox"/>
		Swelling of Joints	<input checked="" type="checkbox"/>
		Back pain	<input checked="" type="checkbox"/>