Associated with Wellness Healthcare Group

Verto Lab — Most trusted health partner

Org. Code : _____ **Date of Collection** D D M M Y Y

Patient Name _____

Age _____ **Gender :** M ☐ F ☐ **Adhaar No.** ☐☐☐☐☐☐☐☐☐☐☐☐

Patient Contact No. ☐☐☐☐☐☐☐☐☐☐ **Alternate No.** ☐☐☐☐☐☐☐☐☐☐

Complete Address : _____

_____

City _____ **State** _____ **Pin Code** _____

Investigations :

- ZN Stain/ AFB Stain ☐
- AFB Rapid Culture ☐
- TB PCR ☐
- CB NAAT / TRU NAAT / Gene Xpert ☐

Symptoms :

- Fever ☐
- Prolonged Cough ☐
- Immune Compromised Disorder ☐
- Fever (Specially at night) ☐
- weight Loss ☐
- Loss Appetitie ☐

HIV Status :

- Negative ☐
- Positive ☐
- Unknown ☐

I confirm that the information provided by me is correct to the best of my knowledge.

Patient Signature _____ Date _____

Instructions for Filling Up Form :

- Please furnish complete clinical details along with request form.
- Do not omit telephone number of Patient / Referring Doctor.
- If the above information is not provided then the Samples / Reports will be put on hold.