Primary Sample Collection Manual

ISO 15189: 2012

for

Laboratory Services of

Centre for Oncopathology
Supported by Tata Trusts

Centre for Oncopathology
3rd floor, Rectifier House,
570, Naigaon Cross Road,
Wadala, Mumbai – 400 031

RELEASE AUTHORIZATION

This Primary sample collection manual is released under the authority of

Dr. Anita Borges

Lab Director

And is the property of

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Sign				
Date				

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RECORD OF REVISIONS

Revision No.	Description	Date of Revision

Primary Sample Collection Manual Distribution Record

The Controlled Copies of primary sample collection Manual are distributed to the following:

Controlled Copy No.	Details of Controlled Copy Holders / Designation	Department	Received By

ABBREVIATIONS

Abbreviation	Full description
COP	Center for Oncopathology
DNA	Deoxyribo Nucleic Acid
HP	Histopathology
MO	Molecular Oncology
RT PCR	Reverse transcription polymerase chain reaction
RNA	Ribonucleic acid
SOP	Standard Operating Procedure
QA	Quality Assurance
ISO	International Organization for Standardization
TAT	Turn Around Time

1. INTRODUCTION:

This Centre for Oncopathology Laboratory is a part of the Alamelu Charitable Foundation, (supported by Tata Trusts) and is situated at Wadala. The laboratory provides the following laboratory services:

a. Histopathology & Cytopathology

b. Molecular Oncology

Centre for Oncopathology Laboratory complies with the requirements of the International Standard ISO 15189:2012 to operate a quality management system for all the testing activities.

2. PURPOSE

Serves as a reference manual for Centre for Oncopathology Personnel, Medical practitioner(s) & referring client(s) and provide relevant information with respect to the laboratory and instructions on collection, handling, packaging, storage and transport of specimens.

This document is a part of quality assurance by brining about uniformity in collection, testing, storage and appropriate disposal of patient samples.

It also contains instructions for patients and/or care givers, as appropriate.

3. SCOPE

Applicable to Centre for Oncopathology Personnel, Referring Medical Practitioner(s) & referring client(s) who are involved in specimen collection, handling, storage and transport to the laboratory.

This document is applicable both to the samples submitted at the reception area of Centre for Oncopathology & samples received by courier services.

4. GENERAL INFORMATION

Working day	Working Hours	Contact	
Monday to Friday	09:30 to 18:30	Phone	022-66496649
Saturday	09:30 to 13:30	WhatsApp	8828036476
		Email	info@oncopath.org
WEB SITE	**www.oncopath.org**		

The Laboratory is closed on Sunday and public holidays as per the list on the website. The directory of services (DOS). Provides details the cut off timings for tests and also the time when test results can be expected.

5. USING THIS DOCUMENT

This document has to be read in conjunction with our DOS that lists the tests that are available in our laboratory Sample requirements & TATs.. In addition to general information common to all tests, specific information is listed under the concerned department's heading.

This document is also available on our website www.oncopath.org. If you need any clarifications or additional copies of this sample collection manual or any of the test request consent forms, please contact us.

Also, the rejection criteria and specific ordering information have been designed keeping in mind the interfering factors for the parameters being tested.

6. CONTACT PERSONNEL

For test result status/logistics or any test related clarification, please contact: Lab Reception at 022 6649 6649 or info@oncopath.org or WhatsApp Number-8828036476.

Our staff, including doctors, are also available for consultation/ clarification about the tests that are available in the laboratory, their intended use, ordering information, result interpretation.

Your queries may be directed telephonically or by email within laboratory working hours.

7. CONSENT

The laboratory treats the requisition forms filled by the referring doctors or the patients, while handing over their biopsy tissues/ slides/paraffin blocks to our laboratory, as implied consent.

8. OUR POLICY ON PROTECTING PATIENT'S PERSONAL INFORMATION

It is our policy to ensure that the patient's personal information is protected. We collect only as much personal information as is required for interpretation of tests or for billing / administrative purposes. Our staff is trained to maintain patient confidentiality.

Test results are released only to the patient or authorized attendant or authorized doctor. Release to someone other than these requires express permission of the patient, except when the situation contravenes the law and the results need to be revealed to appropriate legal agency.

Patient specimens (primary and derived) are not used for any purpose other than requested, except for internal quality control or for validation/ verification or training purposes. Any use of patient sample other than for test/s requested will anonymize the patient details.

9. HOW TO GIVE FEEDBACK / COMPLAINTS / SUGGESTIONS:

A feedback form is available in our reception area as well as on our website www.oncopath.org.

For any feedback/complaints/ queries/ suggestions regarding our services, please write with all details to us at quality@oncopath.org.

Please remember to provide us the complete details of the patient, including the date on which you utilized our service, and your phone number. We will revert to you at the earliest possible.

You can also phone us on 022 6649 6649

10. PATIENT PREPARATION

Successful encounters with patients begin with a professional, respectful, and compassionate approach.

Positive communications should begin by addressing the patient using proper titles such as Ms., Mrs., or Mr.; the inappropriate use of terms of endearment is a common patient complaint.

Laboratory personnel should always introduce and identify themselves to the patient before explaining the upcoming laboratory process. An example is to say, "Good morning. My name is Lilli and I will be your nurse today."

Always conclude the conversation by asking if there are any questions before leaving the room.

If you have a concern about a patient's level of understanding with the conversation, ask the individual to repeat what you have just explained so you can confirm that there are no issues.

When a test requested requires specific preparation, the instructions are explained to the patient / patient's representative by our Laboratory Personnel.

Filling up test request forms and sample collection after appropriate patient identification are detailed in this manual (see table of contents)

11. SAMPLE TRANSPORT / COLLECTION SERVICE

Courier service for specimen pick-up from most of regions within India is available on request. To check whether your area is covered under this courier service, please check on our website.

If required, please contact the lab manager or customer relations or Logistics coordinator (for status of samples sent to us, courier services and sample packing material): at Centre for Oncopathology.

12. PACKAGING FOR COURIER PICKUP

Every patient must have a separate request form. The test request form should be folded and placed along with the specimen in a leak proof bag.

There is a special transport box available for shipping biological samples to us. Please contact the customer care.

This box is labeled appropriately and ensures safety of the courier and general public with provision for maintenance of appropriate temperature.

Slides/ paraffin blocks must be sent in rigid cardboard boxes or mailers.

Temperature to be maintained for the patient samples are mentioned in our directory of lab services if any. In case of ANY doubt, please contact the laboratory.

All universal precautions must be followed during sample packing

13. REQUISITION FORM INSTRUCTIONS

Our test requisition forms can be obtained from the laboratory or can be downloaded from our website www.oncopath.org.

If forms are not available with the referring doctor, tests requested on the doctor's or hospital's letter heads are also accepted- provided all relevant information is available.

A requisition form must accompany all specimens submitted to the laboratory

The following information MUST be completed on the requisition form.

- Patient's full name
- Patient's location (where the report needs to be sent)
- Patient's telephone number and e-mail address
- Patient's gender and date of birth / age
- Provisional Diagnosis
- Name and e-mail address of the requesting physician
- Date and time of specimen collection (for biopsies & surgical resection specimen sent for primary Processing)
- Indicate the requested test(s) clearly. The tests available in our laboratory are detailed in our directory of services
- Please mention the site of the biopsy. For lymph nodes, and retroperitoneal/ abdominal masses, please indicate the exact location of the mass.

❖ **Note:**

- It is important to provide a provisional clinical diagnosis and pertinent history, examination & radiology findings.
- It is required that a copy of the primary report is attached to the request form for slide/block review. This serves two purposes;
    - confirms that the referred material belongs to the patient
    - provides gross findings and section code, which facilitates reporting.
- It is strongly recommended that pre-operative radiology films or CD are submitted for bone & brain cases. These shall be returned along with our report.

14. IDENTIFICATION OF PRIMARY SAMPLE

All tissue specimens that are collected must be legibly labeled with patient's name, age, gender, and a traceable unique identification number (E.g. UHID unique hospital identification or LIS laboratory information system etc.). If slides or paraffin blocks are being sent, they must bear a number which must be verifiable in the accompanying primary pathology report.

15. URGENT / EMERGENCY / STAT

15.1 Urgent test

These include tests in a critically ill patient or after-hours service or any other requests specifically telephoned to the laboratory prior to arrival of the specimen.

The request form must be clearly marked as 'URGENT' or 'STAT'. Special note must be made of the telephone number or other method of contact with the referring doctor.

As soon as the test reports are ready, these will be informed to the requesting doctor telephonically without delay. This will always be followed by a written report

15.2 Procedure for verbal requests

Verbal requests are accepted only in the following situation:

- In an event where a test report needs to be supported or supplemented with an additional test for confirmation of diagnosis, on request of the referring doctor/ his or her representative/walk in patients.
- In a situation where the authorized personnel are not available to fill the request form

Request forms should be filled for all verbal requests and sent to the laboratory as soon as possible and not later than 24 hours.

While taking down the verbal order, the following points are logged by laboratory staff on the request form of the patient

- Name of requesting clinician
- Additional tests
- Person requesting the test
- Authorized person receiving the order in the laboratory

The laboratory may need fresh/additional sample for performing some of the tests ordered verbally, especially for molecular pathology. This information must be checked by the referring doctor/ center with the laboratory while making a verbal request.

16. SAMPLE REJECTION CRITERIA

All specimens should be properly labeled, accompanied by a request form containing the required information, including pertinent clinical information. In order to assure proper patient care, the laboratory will not be able to process specimens that have not been properly labeled. The lab personnel will attempt to contact the doctor and/or person-in-charge of the area where the specimen was collected and resolve the matter.

For sample acceptance,

The decision of the section-in-charge/pathologist/designee of the concerned section or laboratory director will be final.

If a sample is processed with limitations, the nature of the limitation of the primary sample will be mentioned on the report**.**

16.1 Criteria for rejection include (but are not limited to):

- unlabeled or mislabeled specimens,
- quantity of lesional tissue insufficient for analysis.
- Specimens without patient demographics: If a specimen is received without an identifying label or requisition form, or if the requisition form contains discrepant information, that specimen will be rejected until it is properly identified and/or all required information is received.
- Specimens collected in improper containers. e.g. surgical specimens without formalin- these are usually not rejected, but the report will mention the limiting factor.
- Slides will be rejected if received broken, and are beyond repair
- Inadequate tumor in tissue sample for IHC (immunohistochemistry)and molecular studies.
- Samples that are not processed in the laboratory: Thin Prep/Cyto Prep samples or tissue for frozen section or testing for Creutzfeldt-Jakob disease.

16.2 Quantity Not Sufficient (QNS): Specimen volume may not be sufficient to perform the requested tests. In those cases, the submitting location will be notified and requested to obtain more specimen. When multiple tests have been ordered and the available tissue is sufficient for some testing but not all, the ordering doctor / hospital / laboratory will be contacted to select and prioritize the testing to be performed.

17. HISTOPATHOLOGY AND CYTOLOGY

We do not perform the FNA procedure in our laboratory.

We also do not accept Thin Prep/Cyto Prep samples or tissue for frozen section or testing for Creutzfeldt-Jakob disease. in our laboratory for processing.

17.1 COMMON GUIDELINES

- Request forms:

Please write the site of the biopsy/FNA and clinical impression on the request form.

For FNA/ biopsy of retroperitoneal mass/ abdominal mass, please tell us where exactly the mass is or seems to be arising from.

In case of lymph nodes, tell us the location of the node (especially in the neck).

- Specimens:

All specimen containers (or envelopes in case of slides/blocks) should be labeled with the following details at least: patient's full name, age, gender, UHID number and doctor's name.

Histopathology slides must be of adequate technical quality to be diagnostically useful. Criteria to evaluate include adequate tissue fixation, processing, thickness of sections, absence of interfering tissue folds and tears and good staining technique and cover slipping. The sections must be cut from sufficient depth in the block to include the entire tissue plane.

- Cerebrospinal Fluid (CSF)

Specimens should be collected in containers with screw caps and caps tightened securely to prevent leakage when transported.

Specimens should be transported within 1 hr. to laboratory.

17.2 INSTRUCTIONS TO PATIENTS FOR SELF COLLECTED SAMPLES

A. SPUTUM FOR CYTOLOGY EXAMINATION

- Explain to the patient that he/she is to collect a sputum specimen first thing each morning for three days
- Instruct the patient to rinse his/her mouth with water before each collection.
- Have the patient to cough deeply and expectorate directly into the containers.
- Instruct the patient to make sure the lid is tight and swirl the container gently to mix the specimen with the fixative.
- Make sure the container is labeled with the patient's name, age and type of specimen.
- Send specimen to the Laboratory.

B. URINE FOR CYTOLOGY EXAMINATION

- Have the patient drink plenty of fluid before collecting the specimen.
- Early morning first clean voided urine sample is collected in a sterile container

- Label container (not lid) with the patient's name, the specimen type. State specifically whether it is a voided or catheterized specimen
- Male Patient: The prepuce should be retracted and the area (glans penis) cleaned with soap and water. Urine [after voiding and discarding an initial small amount] is collected directly into a sterile, wide mouthed, screw-capped container – Mid stream Urine – clean catch.
- Patients with condom catheters [Unconscious male patients]: The condom should be removed, glans penis cleansed with mild antiseptic, urine collected aseptically with a simple rubber catheter.
- **Female Patient:** vulva should be cleansed with soap and water, other steps as above (as for male patients).
- **Indwelling catheterized patients**: 5-10 ml of urine should be aspirated aseptically from the proximal part of the catheter (If needed, after Clamping) with sterile needle and syringe, after antiseptic application over the surface of the catheter the sample should be collected by a doctor or nursing staff. The closed circuit of drainage of urine should not be disturbed.
- Send the specimen to the Laboratory.

17.3 SURGICAL/HISTOPATHOLOGY, SAMPLE COLLECTION

All specimens should be sent along with the surgical pathology request form with mention of the clinical details, nature and site of specimen sent.

The specimens should be sent in 10% neutral buffered formalin which is at least 10 times the volume of the specimen.

The laboratory may be contacted for instructions/ chemicals required for preparation of buffered formalin. For centers close to the laboratory, the buffered formalin can be provided on request.

For resection specimens, it is recommended that the surgeon notes down the time of finishing the surgery and time of putting specimen in formalin, on the test request form. Time of performing the biopsy of breast and lung lesions will also help us to fix the specimen adequately as per guidelines.

17.4 FOR TISSUE SAMPLES BEING SENT FOR PROCESSING

It is anticipated that lesions will be resected according to a defined surgical protocol. If the surgical resection differs from the protocol, e.g., if dissection does not extend to the deep fascia or skin when this is the norm (e.g., skin sparing mastectomy or modified radical neck dissection), this should be clearly indicated on the request form.

The surgeon should orient the resection specimens. A code of orientation can be established using either different lengths of suture or metal staples/clips or ink. The code should be anatomically relevant and assist in accurate evaluation of the specimen and its margins.

If more than one piece of tissue is removed; it should be made clear how the samples are oriented with respect to each other in order to simplify assessment of the size of the lesion and distance to margins.

Wherever relevant, the radiology findings must be mentioned on the pathology test request form. This will facilitate diagnosis

The specimen should be sent to the laboratory as soon as possible in adequate fixative (10 % neutral buffered formalin is recommended), if a delay in transport is anticipated and by arrangement with the pathologist, the surgeon must make controlled incision/s into the lesion, thus preserving the integrity of key margins while allowing immediate penetration of fixative. The incision should be made from the posterior aspect or from the skin inwards. Hollow viscera must be cut open and then incision/s made in the lesion.

If specimen is a whole lymph node excision biopsy specially for the diagnosis of lymphoma, please bisect it using a sharp knife / scalpel and put it into formalin immediately, Small node less than 1 cm need not be bisected.

Small biopsies may be put in a small bottle/ plain vacutainer containing formalin.

Quantity of formalin added to preserve the tissue specimen in transit, must be just enough to cover the tissue biopsy. For larger specimens, it is recommended that after initial fixation, the specimen is wrapped in formalin-soaked cotton and placed in a strong plastic bag with identifying label.

The bottle or vacutainer must be recapped/ plastic bag should be sealed tightly and additionally fortified by brown tape.

The bottle/ vacutainer/ plastic bag must then be packed in a corrugated cardboard box along with the requisition form and sent to the laboratory.

- **Fixation time**

Special care is taken for primary fixation of breast and lung specimens for 6-48 hours. If primary fixation time is not provided by the referring center, a disclaimer may be added to the report, to that effect.

If slides and blocks are being sent, these should be placed in cardboard slide boxes. Please ensure that the envelope in which the slide box is placed is cloth –lined.

17.5 POLICY FOR RETURN OF SUBMITTED MATERIAL

- **Review Material**

  Slides and paraffin blocks submitted for review will be studied and then returned to the patient along with the pathology report. If only stained slides are submitted, the laboratory will retain representative slides for its records.

- **Tissue processed in the laboratory:**

  Slides, paraffin blocks and remaining tissue (if any) will be retained by the lab as per the retention period policy i.e. slides and paraffin blocks for ten years and remaining tissue (if any) for one month after the date of reporting.

  Slides /blocks of tissue primarily processed in the laboratory are not routinely handed over with the report.if required, patient can obtain slides/ blocks or remaining tissue specimen, within the retention period. Representative slides (stained and/or unstained - PLL coated) or paraffin blocks will be provided after one working day of receiving against a written request. Before handing over the slides/ blocks/specimen, the lab will ensure that representative material is also retained in the lab.

17.6 SAMPLE STORAGE / RETENTION PERIODS

Sr. No.	Type of sample/section	Storage period	Storage temperature
1	Surgical pathology specimens	One month, after reporting	Ambient
2	Body fluids (cytology)	24 hours, after reporting	2-8^{0}C
3	Paraffin blocks and slides	10 years	Ambient
4	Cytology smears (including bone marrow aspirates)	10 years	Ambient

17.7 TIME PERIOD FOR REQUESTS FOR ADDITIONAL /REPEAT TESTS ON THE SAME SAMPLE

- Additional sections on surgical pathology specimens may be taken up to .

- Additional tests on a sample (e.g. Immunohistochemistry) will be undertaken provided that adequate sample is available.
- Additional testing like microbiology culture is not possible on an already tested cytology samples and formalin fixed tissue.
- The section-in-charge / laboratory director will use their discretion to accept/refuse an additional testing.
- Requests for additional/ repeat testing will be accepted verbally, but must always be followed by a written request. Alternatively, the lab personnel may note down on the request form as '……. test verbally requested by…… at ……."
- TAT (Turn Around Time) for repeat/additional tests may be more than those mentioned in the directory of services.

18. MOLECULAR ONCOLOGY

18.1 Instructions

- Paraffin blocks may be sent at ambient temperature (not exceeding 50-degree C).

18.2 Criteria for rejection include (but are not limited):

- The most common reasons for sample rejection are listed below;
- Specimens without patient name or wrong name: If a specimen is received without an identifying label or requisition form, or if the requisition form contains discrepant information, that specimen will be rejected until it is properly identified and/or all required information is received.
- Quantity Not Sufficient (QNS): The amount of tumor tissue may not be sufficient to perform the requested tests. In those cases, the submitting location will be notified and requested to obtain more specimen. When multiple tests have been ordered and the volume is sufficient for some testing but not all, the ordering doctor / hospital / laboratory will be contacted to select and prioritize the testing to be completed.
- In all PCR based analysis, if there is a failure in amplification of the internal control gene, testing will be stopped at that point. The report issued to the patient will provide the reason for testing stopped.
- In NGS technology, if the library concentration of the sample is below 100ng/ml, testing will be stopped at that point. The criteria to stop further testing will be

mentioned on the report; however if testing is continued, the report then issued will provide details of the relevant quality matrix (among other details found).

18.3 SAMPLE STORAGE / RETENTION PERIODS

- Retention period for the sample/specimen

Serial Number	Type of sample/section	Storage period	Storage temperature
1	Isolated DNA and/or/RNA	5 years	-20^0C to -80^0C

18.4 TIME PERIOD FOR REQUESTS FOR ADDITIONAL /REPEAT TESTS ON THE SAME SAMPLE

- Additional tests on a sample will be undertaken provided that the time criteria are met, and adequate sample is available. The section-in-charge / laboratory director will use their discretion to accept/refuse an additional testing.
- Requests for additional/ repeat testing will be accepted verbally, but must always be followed by a written request. Alternatively, the lab personnel may note down on the request form as '……. test verbally requested by…… at ……."
- TAT (turnaround time) for repeat/additional tests may be more than those mentioned in the directory of services.

19. DISCARDING OF SPECIMENS

- All specimens in our laboratory are discarded as given below. The polythene bags of appropriate colour code are placed in each section. These bags with waste are collected from the section by housekeeping, kept in a holding area and then picked up by SMS Envoclean Pvt Ltd an external, government recognized agency which disposes off the waste appropriately.

Table No 03

GUIDELINES FOR HANDLING OF BIO-MEDICAL WASTE

	YELLOW BAG	• **Human anatomical waste**: Human tissues, organs, body parts and fetus below the viability period • **Animal Anatomical Waste:** Experimental animal carcasses, body parts, organs, tissues, including the waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses. • **Soiled Waste:** Items contaminated with blood, body fluids like dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components. • **Expired or Discarded Medicines**: Pharmaceutical waste like antibiotics, cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc. • **Chemical Waste:** Chemicals used in production of biological and used or discarded disinfectants. • **Chemical Liquid Waste:** Liquid waste generated due to use of chemicals in production of biological and used or discarded disinfectants, Silver X-ray film developing liquid, discarded Formalin, infected secretions, aspirated body fluids, liquid from laboratories and floor washings, cleaning, housekeeping and disinfecting activities etc. • **Discarded linen, mattresses, beddings contaminated with blood or body fluid.** • human and animal cell cultures used in research, industrial laboratories, production of biological, residual toxins, dishes and devices used for cultures.

	RED BAG	• Contaminated Waste (Recyclable)-Wastes generated from disposable items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves.
	BLUE BAG	• **Glassware:** Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes. • Metallic Body Implants
	WHITE	• **Waste sharps including Metals:** Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
	BLACK BAG	• All Non-Infectious Waste • Kitchen Waste • Office Waste, Wrapper, Empty Boxes. • Cytotoxic Drugs, Outdated Medicine

20. NEEDLE STICK OR SHARP INJURY

20.1 Immediate care:

- Allow bleeding from the wound.
- Flush exposed mucous membranes with water. Irrigate an open wound with sterile saline or disinfectant.
- Wash the wound or skin sites thoroughly with soap and water or use a waterless cleanser or antiseptic if water is unavailable.
- Apply a waterproof dressing as necessary, and apply pressure through the dressing if bleeding is still occurring.
- Do not squeeze or rub the injury site.

20.2 Precautions

- Avoid the use of needles where safe and effective alternatives are available.
- Always use Personal protective equipment's to reduce the risk of needle stick injury.
- Avoid recapping needles.
- Plan for safe handling and disposal of needles/blades before using them.
- Promptly dispose of used needles/blades in appropriate sharps disposal containers.
- Report all needle stick and sharps-related injuries promptly to ensure prompt and appropriate action.
- Inform the Lab Director if any needle stick hazards are observed.

20.3 Reporting

- All needle stick /Sharp injuries should be reported to the immediate supervisor soon after the incident, for counseling, testing of source patient and post exposure prophylaxis.

21. LIST OF EXAMINATION

The list is available in DOS.

Annexure I

FREQUENTLY ASKED QUESTIONS ABOUT TESTS PERFORMED IN OUR LAB

Why is my doctor ordering this test?

Lab tests are done to diagnose medical conditions, to plan as well as monitor treatment. Please consult your referring doctor if you have questions.

Why do I have to submit a copy of my pathology report with the slides and paraffin blocks?

This serves two purposes

a) confirms that the referred material belongs to the patient and

b) provides gross findings and section code, which facilitates reporting.

Will I get back my biopsy sample with my report?

If slides and paraffin blocks have been submitted, these will be returned to the patient along with the pathology report. If only stained slides are submitted, the laboratory will retain representative slides for its records.

If tissue has been submitted to us for processing, slides /blocks are not routinely handed over with the report. If required, patient can obtain slides/ blocks or remaining tissue specimen, within the retention period. Representative slides (stained and/or unstained) or paraffin blocks will be provided against a written request by the patient or patient's representative or referring doctor.
The remaining material can be issued 24 hrs. after request for the same in intimated to the laboratory.

How soon can I expect to hear the results of my lab tests?

Please refer to our directory of services for our turn-around -times. We make our best effort to issue reports on time; however, delay in reporting can occur due to unforeseen circumstances (technical issues or natural calamities) the laboratory will make all efforts to reduce the delay.

Can you tell me my lab results on the phone?

No. Our policy does not permit us to do so. However, we can inform you when your reports are ready.

Can you tell me what these lab results mean?

It is recommended that you consult your referring doctor. Also, our laboratory doctors can discuss your lab test results with your doctor.