Laboratory BILL

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| --- |
| **Patient Information**  Name: \_\_\_\_\_\_\_\_\_  Age/ Sex:\_\_\_\_\_\_\_\_  Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_  CABG |

|  |
| --- |
| **Lab Information**  **Registration Location:\_\_\_\_\_\_\_\_\_\_\_\_**  **Destination Location:\_\_\_\_\_\_\_\_\_\_\_**  **Registration Date:\_\_\_\_\_\_\_\_\_\_** |

**PATIENT BILL**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S.No. | Test Name | Reporting Date Time | | Rate |
| 1 | BLOOD C/E (complete, CBC)  Hb,WBC Count (TLC), DLC, Total RBC, Platelet count, MCV, MCH, MCHC, Type | Apr 02,2015-04-05 | 20:00 | 500.00 | |
| 2 | ESR | Apr 01, 2015-04-05 | 8:41 | 600.00 | |
| 3 | Vitamin | Apr 01, 2015-04-05 | 8:41 | 5000.00 | |

**TOTAL BILL**

Total: 6100.00

Less/ Discount 100.00

|  |
| --- |
| Paid: 6000.00 |

To be paid: 6000.00

Registered By: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Collection Center:**

Center Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone no.\_\_\_\_\_\_\_\_\_\_\_\_

Fax no.\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_