Dated:___/___/_____

# ATH Publich Health Laboratory
# MTI Ayub Teaching Hospital
# Abbottabad

**Name of Facility :_____**

**Disctrict Name : _____**

| S.No | Patient Name | Father/Husband Name | Age | EPID ID | ATH Medical Record Number |
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**Sample Received by**
**Name**
**Designation**
**Signature _____**

**Forms Received by**
**Name**
**Designation**
**Signature _____**