Source
Pathology Services

DIAGNOSTIC TEST REQUISITION FORM
(Mutation Analysis/IHC/ISH)

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TEST SELECTION			
☐ **KRAS**	☐ **NRAS**	☐ **BRAF**	☐ **MMR**
☐ **EGFR**	☐ **ALK**	☐ **PD-L1**	
☐ **HER2 (IHC/FISH)**	☐ **HER2 (FISH only)**	☐ **ER**	☐ **PR**
Other (Please specify):			

PRIMARY TUMOUR TYPE				
☐ **Colorectal**	☐ **Melanoma**	☐ **Lung**	☐ **Breast**	☐ **Gastric**
Other (Please specify):				

PATIENT INFORMATION		SAMPLE INFORMATION	
LAST NAME:		BLOCK ID/HISTOLOGY No.	
FIRST NAME:		No. BLOCKS SENT:	No. SLIDES SENT:
DOB:		ADDITIONAL COMMENTS:	
☐ FEMALE	☐ MALE		

PERMISSIONS

☐ **For blocks which contain limited tissue it may be necessary to use all remaining tissue. If you DO NOT give permission for this practice please mark this box.**

☐ **If multiple blocks are submitted, all blocks will be tested by default; if 'best block' selection is required please mark this box.**

SENDERS INFORMATION	
NAME:	ADDRESS:
DEPARTMENT:	
PHONE NUMBER:	
SIGNATURE:	DATE:

(FOR INTERNAL USE ONLY) **RESULTS**				
HER2 - IHC	☐ **0**	☐ **1+**	☐ **2+**	☐ **3+**
COMMENTS:				
SIGNED:			DATE:	