

**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

LAST NAME:	
FIRST NAME:	
DOB:	
FEMALE	MALE

SAMPLE INFORMATION

BLOCK ID/HISTOLOGY No.	
No. BLOCKS SENT:	No. SLIDES SENT:
ADDITIONAL COMMENTS:	

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:	

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