

MOLECULAR DIAGNOSTICS TEST REQUISITION FORM [Mutation Analysis/PCR/IHC/ISH]

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TEST SELECTION

<input type="checkbox"/> KRAS	<input type="checkbox"/> NRAS	<input type="checkbox"/> BRAF	<input type="checkbox"/> EGFR
<input type="checkbox"/> HER2 (IHC/ISH)	<input type="checkbox"/> HER2 (ISH only)	<input type="checkbox"/> ER (IHC)	<input type="checkbox"/> PR (IHC)
<input type="checkbox"/> MSI (PCR)	<input type="checkbox"/> MLH1 Promotor Methylation	<input type="checkbox"/> Lung Fusions Panel (PCR)	
<input type="checkbox"/> MMR (IHC)	<input type="checkbox"/> PD-L1 (IHC)	<input type="checkbox"/> ALK (IHC)	<input type="checkbox"/> ROS1 (IHC)
<input type="checkbox"/> OTHER (Please specify):			
FOR 'OTHER' IHC REQUESTS:		<input type="checkbox"/> STAIN AND REPORT	<input type="checkbox"/> STAIN ONLY

PRIMARY TUMOUR TYPE

<input type="checkbox"/> Colorectal	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Lung	<input type="checkbox"/> Breast	<input type="checkbox"/> Gastric
Other (Please specify):				

PATIENT INFORMATION
SAMPLE INFORMATION

LAST NAME:		BLOCK ID/HISTOLOGY No.:	
FIRST NAME:		No. BLOCKS SENT:	No. SLIDES SENT:
DATE OF BIRTH:		ADDITIONAL COMMENTS:	
<input type="checkbox"/> FEMALE <input type="checkbox"/> 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.

SENDER INFORMATION

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

(FOR INTERNAL USE ONLY) RESULTS

HER2 - IHC	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+
COMMENTS:				
SIGNED:			DATE:	

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