HEALTH SERVICES LABORATORIES
ADVANCED DIAGNOSTICS

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IQC	INITIALS	DATE
Cut		
Labelled		
Collated		
QC		
Packaged		

ER IHC REQUEST FORM

FOR LABORATORY USE ONLY

HSL-AD NUMBER:_____ MATERIAL RECEIVED:_____

PRICE (TO BE INVOICED):_____ DATE RECEVED & INITIALS:_____

PATIENT / SAMPLE DETAILS

SURNAME:_____ SURGICAL CASE ID:_____

FORENAME:_____ TUMOUR TYPE & GRADE:_____

DOB:_____ M ☐ F ☐

REFERRING HOSPITAL / INVOICING DETAILS

CONSULTANT:_____

ADDRESS:_____

_____

_____

PHONE:_____

INVOICING DETAILS (if different)

CONTACT NAME:_____

ORGANISATION:_____

ADDRESS:_____

_____

PURCHASE NUMBER:_____

REPORT DELIVERY *(please tick, all reports will also be posted)* **FAX** ☐ **EMAIL** ☐

FAX NUMBER(S):	EMAIL ADDRESS(ES):
_____	_____
_____	_____

ER IHC REPORT

ER IHC RESULT

PROPORTION & INTENSITY SCORE (please circle)

SCORE	% NUCLEI	INTENSITY NUCLEI
0	None	None
1	<1	Weak
2	1-10	Moderate
3	11-33	Strong
4	34-66	
5	67-100	

TEST INFORMATION & COMMENTS

SIGNED:_____ **DATE:**_____

Dr Mary Falzon/Dr Elaine Borg