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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 RECEIVED & 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

#### TEST INFORMATION & COMMENTS

**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	

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Dr Mary Falzon/Dr Elaine Borg