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IQC	INITIALS	DATE
Cut		
Labelled		
Collated		
QC		
Packaged		

HER-2 GASTRIC 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):

HER-2 GASTRIC IHC REPORT

HER-2 IHC RESULT

TEST INFORMATION & COMMENTS

3+ POSITIVE

2+ EQUIVOCAL (FISH will be performed)

1+ NEGATIVE

0 NEGATIVE

If result is 2+ (equivocal) or if FISH is suggested by the reporting pathologist, automatic reflex to HER2 FISH testing will be performed.

SIGNED: _____

DATE: _____

Prof Marco Novelli/Dr Manuel Rodriguez-Justo/Dr Miriam Mitchinson

Dr Alison Winstanley/Dr Marnix Jansen