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IQC	INITIALS	DATE
Cut		
Labelled		
Collated		
QC		
Packaged		

PR 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):

PR IHC REPORT

PR 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