

Directorate of Laboratory Medicine

DIAGNOSTIC MMR TESTING

Immunohistochemistry Laboratory
Dept. of Adult Histopathology
Manchester Royal Infirmary
Oxford Road
Manchester
M13 9WL

Tel: 0161 276

8786

REQUEST FOR MISMATCH REPAIR IMMUNOHISTOCHEMISTRY TESTING

PATIENT DETAILS	REFERRER DETAILS
Surname:	Consultant Surgeon/Oncologist:
Forename(s):	Consultant Histopathologist:
DoB: Sex: M/F	Date of Request:
NHS No:	Address for Reporting:
Hospital No:	
Address:	Tel: Fax: Email: Reported by: □ Email (an 'nhs.net' email account is required)
Postcode:	☐ Fax (a 'safe Haven' fax no is required)
REFERRED MATERIAL DETAILS Please send one tumour and one normal tissue block with a representative H&E slide from each. Also ensure that a copy of the report is also included Referring Laboratory: Normal Tissue Block No: Tumour Tissue Block No:	INVOICING DETAILS Laboratory Manager Name: Contact Email: Purchase Order Number: Please note this is required to process your payment Invoicing Address: Postcode:
CRITERIA FOR TESTING (Please tick) □ Direct Request from Histopathology. Patient <50 years old at time of diagnosis with colorectal adenocarcinoma	
The patient has been discussed at an MDT and;	
☐ Is 50-60 years old and has a tumour with histological features suggestive of Lynch syndrome and a family history of Lynch syndrome related malignancies	
☐ MMR status will aid decision making regarding chemotherapy treatment (oncologist request)	
HIST FORM IHC 032 Edition 003 Page 1 of 1 Date of issue: 19.01.18 CONTROLLED DOCUMENT. FREE TO PRINT	

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