



## IHC/ISH REQUEST FORM

PATIENT DETAILS	
SURNAME	
FORNAME	
DATE OF BIRTH	

REFERRAL DETAILS	
HOSPITAL	
LABORATORY MANAGER	
BLOCK/SLIDE NUMBER(S)	
TISSUE TYPE	

INVOICING DETAILS	
PO NUMBER*	
NAME AND ADDRESS (IF DIFFERENT FROM ABOVE)	

\*Please note that a purchase order numbered is required for us to process and invoice your request

For our current repertoire please visit <http://www.cmft.nhs.uk/info-for-health-professionals/laboratory-medicine/histopathology/immunohistochemistry-and-research>

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IQC - REFFERING LABORATORY			
DATE SECTIONED		INITIALS	
DATE POSTED		INITIALS	

IQC - TESTING LABORATORY			
DATE PERFORMED		INITIALS	
DATE QC'D		INITIALS	
DATE RETURNED		INITIALS	

IHC/ISH TEST(S) REQUESTED



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