

## PD-L1 IHC, ALK IHC and EGFR Mutation Testing

### REQUEST FORM

#### MOLECULAR TEST:

PD-L1

EGFR

ALK

ROS-1

#### SPECIMEN REQUIREMENTS

- PD-L1, EGFR, ALK and ROS-1 tests require the FFPE block containing the tumour material to be sent to Blackpool Victoria Hospital so that a fresh section can be cut prior to sample preparation.

- A copy of the original pathology report **must** be provided.

#### PATIENT/SPECIMEN DETAILS:

SURNAME: \_\_\_\_\_

NHS NUMBER: \_\_\_\_\_

FORENAME: \_\_\_\_\_

HOSPITAL NUMBER: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

GENDER: M / F

TUMOUR TYPE: \_\_\_\_\_

SAMPLE TYPE: \_\_\_\_\_

FIXATION METHOD: \_\_\_\_\_

LAB NUMBER: \_\_\_\_\_

#### CLINICAL INFORMATION:

(Please Include as much details as possible including past illness, past treatments and current clinical symptoms)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### REFERRING HOSPITAL DETAILS

HOSPITAL: \_\_\_\_\_

CONSULTANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

MDT COORDINATOR DETAILS: \_\_\_\_\_

#### INVOICE DETAILS

CONTACT NAME: \_\_\_\_\_

ORGANISATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PURCHASE NUMBER: \_\_\_\_\_

#### REPORT DELIVERY

POSTAL ADDRESS

FAX:

EMAIL ADDRESS:

