

HER2 FISH TEST REQUISITION

All Fields Must Be Completed LEGIBLY (Patient demographics must be filled in, if not addressographed).

PATIENT NAME (LAST, FIRST):

PERSONAL HEALTH NUMBER (PHN):

CERNER MEDICAL RECORD NUMBER(MRN):

DATE OF BIRTH (dd,mmm,yy):

SEX: M F U X

BC CANCER PATIENT: Y N

REQUESTING PHYSICIAN (LAST, FIRST):

MSP NUMBER:

PHONE NUMBER:

FAX NUMBER:

COPY TO: NAME (LAST, FIRST)

MSP NUMBER:

COPY TO: NAME (LAST, FIRST)

MSP NUMBER:

SPECIMEN INFORMATION:

ORIGINATING HOSPITAL:

SPECIMEN NUMBER:

PROCEDURE DATE (dd,mmm,yy):

TUMOUR TYPE: DUCTAL (NOS) LOBULAR MUCINOUS OTHER:

BIOPSY TYPE: EXCISION CORE BIOPSY FNA CELL BLOCK

IMMUNOHISTOCHEMISTRY RESULT - INTENSITY: 0 1 2 3 PERCENT STAINED: %

ANTIBODY USED:	VENTANA 4B5	HERCEPTEST	CB11
	DAKO A0485	SP3	OTHER:

Instructions for Originating Hospital

Please send the tissue block to be tested and a HER2 immunostained slide (or 3 unstained slides on "PLUS" slides, an H&E stained slide and a HER2 immunostained slide). Include this requisition and a copy of the pathology report.

Send All To:

Pathology Office - Room 3225
BC Cancer Agency
600 West 10th Avenue
Vancouver, BC V5Z 4E6

Any questions, please contact: BCCAPathClerks@bccancer.bc.ca

REQUESTING PHYSICIAN SIGNATURE:

DATE SIGNED: