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| Document Code: | PMP_X090 | Date of Issue: | 17/05/2022 |
| Version Number: | 2.2 | | |

COLORECTAL CANCER MOLECULAR TESTING REQUEST FORM

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|---------------------|--------------------------|-------------------|--------------------------|---------------|--------------------------|
| KRAS Mutation | <input type="checkbox"/> | NRAS Mutation | <input type="checkbox"/> | BRAF Mutation | <input type="checkbox"/> |
| Mismatch Repair IHC | <input type="checkbox"/> | MLH-1 Methylation | <input type="checkbox"/> | NTRK Fusions | <input type="checkbox"/> |
| HER-2 Amplification | <input type="checkbox"/> | | | | |
| Additional testing: | | | | | |

| PATIENT DETAILS | | | | | |
|-----------------|------|--|-----------|---------|--|
| SURNAME: | | | FORENAME: | | |
| DOB: | SEX: | | NHS No: | | |
| HOSPITAL No: | | | ROUTINE: | URGENT: | |

| REFERRING CLINICIAN & REPORT DESTINATION | | | | | |
|---|--|--------------------------------------|------------------------------------|--|--|
| NAME: | | | HOSPITAL: | | |
| EMAIL: | | | TEL: | | |
| REPORT DESTINATION .NET EMAIL(s): | | | | | |
| PLEASE TICK TO INDICATE INVOICING PREFERENCE: | | <input type="checkbox"/> PATHOLOGIST | <input type="checkbox"/> PHYSICIAN | | |

| SAMPLE / CLINICAL DETAILS | | | |
|---------------------------|----------------|--------------|------------|
| PATHOLOGY HOSPITAL: | | | DATE SENT: |
| REPORT / PATHOLOGY No: | | SPEC TYPE: | |
| SECTION CUT DATE: | DRYING LENGTH: | DRYING TEMP: | |

| SPECIMEN REQUIREMENTS | MOLECULAR CONTACT DETAILS |
|---|---|
| <ul style="list-style-type: none"> Details of block requirement / section preparation can be found on our website: qehbpathology.uk Please supply copy of original Histopathology report. Residual material will be returned to you as soon as possible. | <p>Please send material to: The Molecular Pathology Diagnostic Service Clinical Laboratory Services, Level -1 Queen Elizabeth Hospital Birmingham, Mindelsohn Way, B15 2WB T : 0121 3713320 / 13325 E : mpds.enquiries@nhs.net</p> |

| UHB LAB USE ONLY – PLEASE DO NOT COVER | | | |
|--|--------------------|------------|--------------------|
| DATE SENT: | DATE RECV'D: | RECV'D BY: | MATERIAL: |
| BOOKED IN: | BOOKING CHECK: | | |
| UHB REG: ZP | | | TISSUE ASSESSMENT: |
| SECTIONING STAFF: | BLOCK/SLIDE CHECK: | | |
| SPECIAL CUTTING INSTRUCTIONS: | | | |