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## NTRK FUSION TESTING REQUEST FORM

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	<input type="checkbox"/>

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"> <li>Details of block requirement / section preparation can be found on our website: <a href="http://qehbpathology.uk">qehbpathology.uk</a></li> <li>Please supply copy of original Histopathology report.</li> <li>Residual material will be returned to you as soon as possible.</li> </ul>	<p><b>Please send material to:</b>  The Molecular Pathology Diagnostic Service  Clinical Laboratory Services, Level -1  Queen Elizabeth Hospital – Birmingham  B15 2WB  <b>T : 0121 3713320 / 13325</b>  <b>E : <a href="mailto:mpds.enquiries@nhs.net">mpds.enquiries@nhs.net</a></b></p>

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