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SARCOMA MOLECULAR TESTING REQUEST FORM

EWSR1 FISH		FUS FISH			SS18 I	FISH		DDIT3 F	ISH				
TFE3 FISH		USP6 FISH			WWTF	R1 FIS	SH 🗆	CIC FIS	Н				
NR4A3 FISH		FOXO1 FISH			PAX3	FISH		COL1A1	I-PDGF	В			
MDM2 Amplification Beta Catenin N					Mutatio	n		IDH Mut	ation				
Next Generatio	arcoma v2												
Additional testing:													
DATIENT DETAIL C													
PATIENT DETAILS SUBMANE: EODEMAN													
SURNAME: DOB: SEX:				FORENAME: NHS No:									
HOSPITAL No:)LX.			-		URGE	NT·					
HOSPITAL No: ROUTINE: URGENT:													
REFERRING CLI	NICIAN												
NAME: HOS					HOSPITA	AL:							
EMAIL: TEL:							1	1		T			
PLEASE TICK TO INDICATE INVOICING PREFERENCE: PATHOLOGIST PHYSICIAN													
SAMPLE / CLINICAL DETAILS													
PATHOLOGY HOSPITAL (if different to above): DATE SENT:													
REPORT / PATHOLOGY No: SPEC TYPE:													
KNOWN DECALCIFICATION PROCESSES:													
SPECIMEN REQUIREMENTS							MOLECULAR CONTACT DETAILS						
Please do not send clipped corner slides.							The Molecular Pathology Diagnostic Service						
 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. 						nd on	Clinical Laboratory Services, Level -1 Queen Elizabeth Hospital Birmingham, B15 2WB T: 0121 3713320 / 13325						
- Residual illaterial will be returned to you as soon as post					possible	E: mpds.enquiries@nhs.net							
				MPD	S OFFICE	USE							
DATE RVD:	RVD BY:					MATERIAL:							
BOOKED: CHECKED: REG: ZP													
REG. ZP				MPDS L	ABORATO	ORY US	SE						
1						TIONING CHE	CK:						
TUMOUR CONTENT:				HE ASSESSOR NAME:									
				HE ASSESSMENT DATE:									
TEST TYPE:		IHC FI		SH IDY				1					
		IHC		FI	SH		IDYLLA	DNA	١	RNA	\		
CUTTING		IHC x 3u	ım		SH x 2um		5um	DNA 2 x 6u		RNA 10 x 6ı			
CUTTING REQUIREMENTS:									ım		um		
	DN:	x 3u x 4u YES	ım		x 2um		5um	2 x 6u 3 x 6u	ım	10 x 6	um		