HI-TECH LAB REQUEST FORM

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ilac-MRA

QUALITY ASSURANCE Q DMSc

Accreditation No. 4144/57

LAB NO.....

Name.....Date of Birth.....Age.....Sex.....

Clinic / Hospital.....Ward.....H.N.....

Tel.....Email.....

Attending physician.....Date of operation / request.....

CLINICAL DATA...

Clinical Hx : .....

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Clinical DDx : .....

Type of Operation : .....

OB-GYN

Para.....

LMP.....

Previous PAP.....

SKIN BIOPSY

- ❑ Punch
- ❑ Shave
- ❑ Excision
- ❑ Incision
- ❑ Wide excision

REQUEST FOR...

- ❑ Histopathology
- ❑ Cytopathology
- ❑ Cell Block
- ❑ Frozen section
- ❑ Histochemistry, specify.....
- ❑ Rapid service (Extra charge)
- ❑ Slide Consultation
- ❑ Immunohistochemistry (IHC), specify.....
- ❑ IHC for Breast markers ◯ ER ◯ PR ◯ HER2 ◯ p53 ◯ Ki-67
- ❑ IHC for Lymphoma panel

Molecular study *

- ❑ HER-2 DISH
- ❑ Gene rearrangement, specify.....
- ❑ PCR for M.tuberculosis
- ❑ Mutation detection, specify.....
- ❑ FISH, specify.....
- ❑ Other, specify.....

Pathologist

- ❑ Requested (Name).....
- ❑ Not specified

SPECIMEN DATA...

Total number of containers (or slides).....

No. 1 Specimen of..... Size : ◯ <5 cm ◯ >5 cm

No. 2 Specimen of..... Size : ◯ <5 cm ◯ >5 cm

No. 3 Specimen of..... Size : ◯ <5 cm ◯ >5 cm

No. 4 Specimen of..... Size : ◯ <5 cm ◯ >5 cm

No. 5 Specimen of..... Size : ◯ <5 cm ◯ >5 cm

* Note : Non-Accredited Test