

**GASTRIC HER2
Requisition Form**

Source BioScience
Reference Laboratory
1 Orchard Place
Nottingham Business Park
Nottingham, NG8 6PX
Tel. +44(0)115 973 9012
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I: PATIENT INFORMATION		SAMPLE INFORMATION ALL SAMPLES (BLOCKS OR SLIDES) MUST BE ACCOMPANIED BY A REQUISITION FORM	
LAST NAME		HISTOLOGY No / BLOCK ID.	
FIRST NAME		SPECIMEN TYPE	
DOB (DD-MMM-YYYY) <input type="checkbox"/> Female <input type="checkbox"/> Male		No. OF BLOCKS SENT	
NHS/PATIENT No.		No. OF SLIDES SENT	
II: REQUESTING CLINICIAN INFORMATION			
CLINICIAN NAME:		ADDRESS:	
ORGANISATION NAME:		CITY	
PHONE		SIGNATURE	
EMAIL		DATE (DD-MMM-YYYY)	
FAX NUMBER FOR RESULT (if required)		PRINTED NAME	
		POSITION	
III: ADDITIONAL INFORMATION			

IV: PURCHASE ORDER DETAILS (if applicable)
PURCHASE ORDER NUMBER:
BILLING ADDRESS:
The provision of Reference Laboratory Services by Source BioScience UK Limited is subject to Source BioScience's standard Terms and Conditions of Supply of Reference Laboratory Services July 2007 which can be obtained from Source BioScience directly by telephone request on 0115 973 9012. Each submission of a Request Form for Reference Laboratory Services issued by a Client to Source BioScience will be deemed to be an acceptance by the Client of the purchase of Services subject to the aforementioned Terms and Conditions of Supply of Reference Laboratory Services. IF SUBMITTING REQUEST FOR NON-NHS PATIENT PLEASE COMPLETE ADDITIONAL PAYMENT INFORMATION <u>PLEASE NOTE: PAYMENT INFORMATION MUST BE COMPLETED IN ORDER FOR THE TEST TO PERFORMED</u>

FOR INTERNAL USE ONLY

DATE RECEIVED..... SIGNED.....

RESULTS

HER2 - IHC 0 1+ 2+ 3+

COMMENTS:

This case should be regarded as negative / borderline / positive for HER2 overexpression

Signed..... Consultant Histopathologist Date.....

For lab use only: Sections cut by..... Date.....

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PAYMENT DETAILS

PLEASE ENSURE YOU COMPLETE ONE OF THE PAYMENT OPTIONS BELOW

V: PATIENT INFORMATION

PATIENT NAME:

NHS/HISTOLOGY NUMBER:

VI: INFORMATION REQUIRED TO ACCEPT PAYMENT VIA CREDIT/DEBIT CARD

CARD TYPE

CARD NUMBER

CARDHOLDERS NAME

BILLING ADDRESS (FOR INVOICING)

CITY

COUNTY

POSTCODE

COUNTRY

VALID FROM (IF PRESENT) (MM-YY)

EXPIRY DATE (MM-YY)

COST OF TEST(S)

VII: INFORMATION REQUIRED TO ACCEPT PAYMENT VIA INSURANCE

INSURANCE COMPANY

EXCESS? YES NO IF YES PLEASE STATE AMOUNT AND COMPLETE SECTION VIII:

POLICY NUMBER

AUTHORISATION CODE

INSURANCE AGENT CONTACT NAME

INSURANCE AGENT CONTACT PHONE NUMBER