

**HER2, ER and PR
Requisition Form**

Source BioScience
Reference Laboratory
1 Orchard Place
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Nottingham, NG8 6PX
Tel. +44(0)115 973 9012
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<input type="checkbox"/> HER2 (Please note in the case of an equivocal (2+) result a FISH test will automatically be performed) [if sections – 4 needed]	<input type="checkbox"/> ER – Oestrogen Receptor [if sections – 2 needed]
<input type="checkbox"/> FISH only [if sections – 3 needed]	<input type="checkbox"/> PR – Progesterone Receptor [if sections – 2 needed]
	<input type="checkbox"/> Full profile (Her2 + FISH if required, with ER and PR) [if sections – 7 needed]

I: PATIENT INFORMATION	SAMPLE INFORMATION ALL SAMPLES (BLOCKS OR SLIDES) MUST ACCOMPANY THIS 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:
<small>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.</small>
<small>IF SUBMITTING REQUEST FOR NON-NHS PATIENT PLEASE COMPLETE ADDITIONAL PAYMENT INFORMATION</small>
<small>PLEASE NOTE: PAYMENT INFORMATION MUST BE COMPLETED IN ORDER FOR THE TEST TO PERFORMED</small>

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.....

Additional comments:

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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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE STATE AMOUNT AND COMPLETE SECTION VIII:			
POLICY NUMBER		AUTHORISATION CODE	
INSURANCE AGENT CONTACT NAME		INSURANCE AGENT CONTACT PHONE NUMBER	