Laboratory Medicine

Breast Cancer
Bio-Marker Requisition

Name:

HCN:

Date of Birth:

REQUEST DATE: DD/MONTH/YYYY

TEST(S) REQUESTED:
- ☐ **ER,PR(Estrogen/Progesterone Receptor)**
- ☐ **HER2 (Human Epidermal growth factor Receptor2)**

Diagnosis: ______________________________

____

A copy of the pathology report should be submitted with test requests

- All breast bio-markers have been validated with tissue fixed in 10% neutral buffered (pH 7.2 -7.4) formalin for a minimum of 24 hours
- Microwave processed and decalcified samples are **not** suitable for testing

Specimen Identification:

Specimen Accession Number: ______________

Number of Blocks Sent: ______________ Block Identifier(s): ______________

Number of Slides Sent: ______________ Slide Identifier(s): ______________

Procedure Type:	**Tissue Location:**	**Fixative Used:**	**Fixation Duration**
☐ Core Biopsy	☐ Right Breast	☐10% Neutral Buffered Formalin	☐ Less than 8 hours
☐ Wire Localization	☐ Left Breast	☐ Other: ______________	☐ Less than 24 hours
☐ Lumpectomy	☐ Other: ______________		☐ 24 to 72 hours
☐ Mastectomy			☐ Greater than 72 hours
☐ Other: ______________			☐ Unspecified time

Referring Pathologist and Reporting Information: *(Please print all information)*

Referring Pathologist: ______________________________

Hospital: ______________________________

Address: ______________________________

Telephone: ______________ Fax: ______________

For Lab Use Only

Ch-1061 2019/06