



Addressograph

# HER 2 FISH TEST REQUISITION

**Shaded fields must be completed LEGIBLY** (Patient demographics must be filled in, if not addressographed).

Patient Name (last,first) \_\_\_\_\_ PHN \_\_\_\_\_ Expiry (mm / yy) \_\_\_\_\_

Date of Birth (d/m/y) \_\_\_\_\_ Sex  M  F  BCCA Patient  Yes  No BCCA No. \_\_\_\_\_

Requesting Physician \_\_\_\_\_ MSC \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Report copy to (all information is necessary to receive a report)

Name: \_\_\_\_\_ MSC \_\_\_\_\_ Address \_\_\_\_\_

Name: \_\_\_\_\_ MSC \_\_\_\_\_ Address \_\_\_\_\_

## Sample

Originating Hospital \_\_\_\_\_ Specimen # \_\_\_\_\_ Procedure Date(d/m/y) \_\_\_\_\_

Biopsy Site \_\_\_\_\_

Tumour Type:  Ductal, NOS  Lobular  Mucinous  Other \_\_\_\_\_

Biopsy Type:  Excision  Core Biopsy  FNA Cell Block  FNA Smear

Immunohistochemistry Result:- Intensity  0  1  2  3 Percent Stained \_\_\_\_\_ %

Antibody Used:  Ventana 4B5  Dako A0485  Other \_\_\_\_\_

## Instructions for Originating Hospital

Please send the block of tissue to be tested and a HER2 Neu immunostained slide (or 3 unstained slides on "PLUS" slides, an H&E stained slide and a HER2 Neu immunostained slide). Include this requisition and a copy of the pathology report.

Send all to:

**Pathology Office - Room 3225  
BC Cancer Agency  
600 West 10th Avenue  
Vancouver, BC V5Z 4E6**

Questions? Please call 604-877-6000 ext.2073