

GASTRIC HER2 REQUEST FORM

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IQC	INITIALS	DATE
CUT		
LABELLED		
COLLATED		
QC		
PACKAGED		

FOR LABORATORY USE ONLY

UCL-AD number: _____ Material received: _____
Price(to be invoiced): _____ Date received & Initials: _____

NB. A HER2 ISH test will be automatically performed in the case of an equivocal (2+) IHC result

PATIENT/SAMPLE DETAILS

SURNAME: _____
FORENAME: _____ SURGICAL CASE ID: _____
DOB: _____ M F

REFERRING HOSPITAL/INVOICING DETAILS

CONSULTANT: _____ INVOICING DETAILS (if different)
ADDRESS: _____ CONTACT NAME: _____
ORGANISATION: _____
ADDRESS: _____
PHONE: _____
FAX: _____

GASTRIC HER2 IHC REPORT

HER-2 IHC RESULT

- 3+ positive
2+ equivocal (ISH will be performed)
1+ negative
0 negative

COMMENTS:

If result is 2+ (equivocal) please refer to HER2 (ERBB2) gene amplification status as determined by ISH.

Tumour type: _____

SIGNED: _____

DATE: _____

Prof Marco Novelli/Dr Manuel Rodriguez-Justo/Dr Alison Winstanley/
Dr Miriam Mitchinson/Dr Marnix Jansen