

MUTATION ANALYSIS REQUEST FORM



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PLEASE INDICATE THE MOLECULAR TEST(S) REQUIRED

KRAS

EGFR

BRAF

FOR LABORATORY USE ONLY

UCL-AD number: _____

Material received: _____

Price(to be invoiced): _____

Date received: _____

PATIENT/SAMPLE DETAILS

SURNAME: _____

SURGICAL CASE ID: _____

FORENAME: _____

TISSUE TYPE: _____

DOB: _____ M F

TUMOUR TYPE: _____

PERCENTAGE TUMOUR IN SAMPLE: _____

REFERRING HOSPITAL/INVOICING DETAILS

REQUESTING CONSULTANT DETAILS

CONSULTANT: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Please tick here if a fax result is required

NB. Reports can only be sent to a secure fax line; by ticking this box you are indicating the line is secure.

Please note that the report shall be sent to the requesting consultant only.

INVOICING DETAILS (if different from requesting details)

CONTACT NAME: _____

ORGANISATION: _____

ADDRESS: _____

ADDRESS FOR RETURN OF MATERIAL (if different from requesting details)

Please note, if this area is left blank, all tissue will be returned to the requesting consultant.