MUTATION ANALYSIS REQUEST FORM

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UCL Advanced Diagnostics

LAB QC (INITIAL)

1. Receipt_____

2. Prep _____

3. Report _____

PLEASE INDICATE THE MOLECULAR TEST(S) REQUIRED

KRAS ☐ **EGFR** ☐ **BRAF** ☐ **NRAS** ☐

FOR LABORATORY USE ONLY

UCL-AD number:_____ Material received:_____

Price(to be invoiced):_____ Date received:_____

PATIENT/SAMPLE DETAILS

SURNAME:_____ **TISSUE TYPE:**_____

FORENAME:_____ **PRIMARY SITE (please tick):**

DOB:_____ **M** ☐ **F** ☐ Colorectal ☐ Lung ☐ Skin ☐

Other:_____

SURGICAL ID:_____ **TUMOUR SUBTYPE:**_____

ESTIMATED PERCENTAGE OF TUMOUR NUCLEI IS ESSENTIAL. If less than 5%, please send an H+E section for assessment. 5-20% ☐ 21-50% ☐ 51-75% ☐ >75% ☐

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.