

<i>Case number</i>

TEST REQUIRED:	KRAS <input type="checkbox"/>	EGFR <input type="checkbox"/>	BRAF <input type="checkbox"/>	ALK <input type="checkbox"/>
REQUESTER DETAILS				
Name of Reporting Pathologist				
Hospital Name				
Address for return of block (if appropriate)				
Telephone Number				
Name of Requesting Clinician				
Secure Fax Number for Report				
HISTOLOGY AND PATIENT IDENTIFIERS				
Patient Surname		Patient First Name		
Date of Resection / biopsy		Date of Birth	/ /	
Histology Number		Gender	M / F	
Tumour Site		Hospital No.		
Cancer Histological Type:		NHS No.		
SAMPLE DETAILS:				
Please enclose EITHER ♦ Representative block (this will be returned within 2 weeks of receipt) OR ♦ Six 10 microns unstained sections on uncoated slides PLUS ♦ One 4 micron unstained section for H&E staining PLUS ♦ Histology report				

SEND BLOCK OR SLIDES WITH THIS FORM AND COPY OF HISTOLOGY REPORT TO:

Address: Department of Histopathology, King's College Hospital, Denmark Hill, London, SE5 9RS
Telephone: 020 3299 3091 Fax: 020 3299 3670 Contact: Dr. Jane Moorhead (Clinical Scientist)
e-mail: jane.moorhead@nhs.net

REFERRING PATH DEPT	Date sample sent	/ /	Signature:
RECEIVING LAB AT KCH	Date sample received	/ /	Signature:

RESULTS (please allow 2 weeks from specimen receipt at KCH to notification of result)	
K-RAS <input type="checkbox"/>	EGFR <input type="checkbox"/> BRAF <input type="checkbox"/> ALK <input type="checkbox"/>
Wild Type	<input type="checkbox"/> (Please see the full report)
Mutation Detected	<input type="checkbox"/> (Please see the full report)
Sample Failure in Test	<input type="checkbox"/> (Please see the full report)

COMMENTS	
DATE RESULT SENT	/ /
SIGNATURE	