PUERTO RICO PATHOLOGY
...your expert lab since 1954

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# IMMUNOPATHOLOGY SERVICE REQUISITION

Patient's Name: _____ (M or F)

Address: _____

_____

DOB _____/_____/_____ Telephone: _____
(MM/DD/YYYY)

Insurance plan: _____

Employer's company name: _____

Contract number: _____

Group number: _____

## TEST REQUESTED

**Breast** (Cold ischema time: _____ Fixation time: _____)
- ☐ ER
- ☐ PR
- ☐ Her2 (equivocal results (2+) will be reflexed to FISH)
- ☐ KI-67

**Colorectal**
- ☐ MMR/IHC - MLH1 MSH2 MSH6 PMS2
- ☐ BRAF/V600
- ☐ KRAS
- ☐ NRAS
- ☐ BRAF

**Neuroendocrine Tumors**
- ☐ Ki-67

**Stomach and GEJ**
- ☐ Her-2

**Lung**
- ☐ EGFR ☐ ALK ☐ ROS 1 ☐ PD-L1

**Molecular**
- ☐ Flow cytometry
- ☐ Cytogenetic
- ☐ FISH Analysis
- ☐ BCR-ABL1 Screening p190+p210
- ☐ BCR-ABL1 Follow-up:
  (select ☐ p190 or ☐ p210)
- ☐ JAK2 V617F ☐ JAK2 reflex Exon 12
- ☐ JAK2 reflex
- ☐ CALR
- ☐ MPL
- ☐ igVH (CLL/SLL)
- ☐ IGH-BCL2

**Solid Tumors:**
- ☐ Immunohistochemistry (IHC)
  Specify: _____
  _____

**Note:** In order to process the test it is necessary to receive:

1. Paraffin Block (s) 2. Slide (s) 3.Pathology Report

☐ Pick-up materials at medical office.
☐ Pick-up at originating laboratory (patient must fill authorization form bellow)
☐ Patient will deliver materials.

I _____, hereby authorize Puerto Rico Pathology to pick up the above mentioned materials from _____ Laboratory, pertaining to my specimen #_____.

Patient Signature _____ Date: _____

Contact person and phone number:

Physician Signature: _____ Date: _____

NPI: _____ License: _____

ICD-10_____

**All received material will be returned to the referring physician 10 days after case is sign off.**
**To access online report, please call our customer service department.**

## PHONE: (787) 726-5486