Request for Laboratory Services
HISTOPATHOLOGY DEPARTMENT
Central Pathology Laboratory,
St. James's Hospital, Dublin 8.
Tel.: 4162063

Date/Time Received:

FOR LABORATORY USE ONLY.
PLEASE AFFIX SPECIMEN NUMBER
BARCODE LABEL HERE

Request Details (Complete Fully OR Attach an Addressograph Label inside the dotted line below):

Hospital

Patient's MRN

Surname

First Name

Date of Birth / / **Male** **Female**

Patient's Address: _____

Consultant's Name:

Ward or Clinic Name:

Signature of Person Making the Request:

Contact Number for urgent results:

Clinical Details:

Please tick to confirm that the following items are accompanying the request form:

The Histopathology Report from the Requesting Location **Referring Hospital Laboratory Number:**

The block(s)/slide(s) to be analysed **Please specify the number of blocks/slides referred: Blocks [ ] Slides [ ]**

Tests Requested (Please tick):

	FLUORESCENT ISH (FISH)	
1	MYC Break Apart	[ ]
2	IGH/MYC t(8;14)(q24:q32) Fusion	[ ]
3	BCL2 Break Apart	[ ]
4	IGH/BCL2 t(14;18)(q32:q21) Fusion	[ ]
5	BCL6 Break Apart	[ ]
6	MALT1 Break Apart	[ ]
7	IGH/CCND1 t(11:14)(q13:q32) Fusion	[ ]
8	DUSP22/IRF4 Break Apart	[ ]
9	TP63/3qtel Break Apart	[ ]
10	EWSR1 Dual Colour Break Apart	[ ]
11	MDM2/CEN12 Dual Colour	[ ]

	CHROMOGENIC ISH (CISH)	
1	Epstein Bar Virus (EBVISH)	[ ]
2	Human Papilloma Virus (HPVISH)	[ ]

If diagnosis is DLBCL, GCB subtype, ? Double-Hit Lymphoma (tests 1-5 will be performed).
If diagnosis is DLBCL, NGC subtype (tests 1-2 will be performed).

Date of Collection of original specimen:___/___/_____

Case reviewed and final choice of tests confirmed.
Signature of Reviewing Pathologist:_____Date:____/___/_____