

PHYSICIAN INFORMATION:

Physician Name: _____

GLOBAL TC

BILL TO: HOSPITAL INSURANCE

SPECIMEN TYPE:

OF UNSTAINED CHARGED SLIDES* (preferred): _____

OF PARAFFIN BLOCKS*: _____

*Unstained, Charged Slides are preferred for staining scanning.

TEST REQUEST:

IHC STAIN ONLY IHC STAIN & SCAN

SLIDE # / BLOCK ID	ANTIBODY MARKERS
A	
B	
C	
D	

ANTIBODY MARKERS:

Please check stains needed below. For multiple sites, use chart above.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AFB(- / +) | <input type="checkbox"/> CD79a | <input type="checkbox"/> HER-2 NU (CERB-2 ONCO PROTEIN) | <input type="checkbox"/> PAX2 |
| <input type="checkbox"/> ALB PAS | <input type="checkbox"/> CD99 | <input type="checkbox"/> HESH | <input type="checkbox"/> PAX5 |
| <input type="checkbox"/> Alcian Blue | <input type="checkbox"/> CD117 | <input type="checkbox"/> HHV8 | <input type="checkbox"/> PAX8 |
| <input type="checkbox"/> ALK-1 | <input type="checkbox"/> CD123 | <input type="checkbox"/> H. Pylori | <input type="checkbox"/> PCK (AE1/AE3) (Multicytokeratin - MCK) |
| <input type="checkbox"/> Alpha Feto Protein | <input type="checkbox"/> CD138 | <input type="checkbox"/> HPL (IHC) | <input type="checkbox"/> PDL 1 (22C3) |
| <input type="checkbox"/> Amyloid A | <input type="checkbox"/> CD163 | <input type="checkbox"/> HPV IHC Comprehensive | <input type="checkbox"/> PDL 1 (73-10) |
| <input type="checkbox"/> Amyloid P | <input type="checkbox"/> CD246 (ALK) | <input type="checkbox"/> HPV IHC Low Risk (6,11,16,18) | <input type="checkbox"/> PDL 1 (E1L3NR) |
| <input type="checkbox"/> ARGINASE1 | <input type="checkbox"/> CDX-2 | <input type="checkbox"/> HPV IHC High Risk (31,33,51) | <input type="checkbox"/> PIN 4 (Prostate Triple Stain) |
| <input type="checkbox"/> BAP1 | <input type="checkbox"/> CEA (M) | <input type="checkbox"/> HMB45 (Melanoma Marker) | <input type="checkbox"/> PLAP |
| <input type="checkbox"/> BCL 1 (Cyclin D1) | <input type="checkbox"/> CEA (P) | <input type="checkbox"/> HNF-1 Beta | <input type="checkbox"/> PMS2 |
| <input type="checkbox"/> BCL2 | <input type="checkbox"/> Chromogranin A | <input type="checkbox"/> HSV I | <input type="checkbox"/> PR |
| <input type="checkbox"/> BCL6 | <input type="checkbox"/> CK 5/6 | <input type="checkbox"/> HSV II | <input type="checkbox"/> Prolactin |
| <input type="checkbox"/> BER-EP4 | <input type="checkbox"/> CK 7 | <input type="checkbox"/> hTERT | <input type="checkbox"/> Prostein |
| <input type="checkbox"/> Beta Catenin | <input type="checkbox"/> CK19 | <input type="checkbox"/> Inhibin A | <input type="checkbox"/> PSA (prostatic specific antigen) |
| <input type="checkbox"/> BOB-1 | <input type="checkbox"/> CK20 | <input type="checkbox"/> KAPPA | <input type="checkbox"/> PSAP (prostate specific alkaline antigen phosphatas) |
| <input type="checkbox"/> CA19-9 | <input type="checkbox"/> CK903 (HMWCK or K903) | <input type="checkbox"/> KDX1 | <input type="checkbox"/> PTEN |
| <input type="checkbox"/> Calcitonin | <input type="checkbox"/> CMV | <input type="checkbox"/> KI67 | <input type="checkbox"/> PT1 |
| <input type="checkbox"/> Caldesmon | <input type="checkbox"/> C-MYC | <input type="checkbox"/> LAMBDA | <input type="checkbox"/> Renal Cell Carcinoma (RCC) |
| <input type="checkbox"/> Calponin | <input type="checkbox"/> Congo Red | <input type="checkbox"/> MAMMAGLOBIN | <input type="checkbox"/> Reticulin |
| <input type="checkbox"/> Calretinin | <input type="checkbox"/> Crystal Violet | <input type="checkbox"/> MELAN-A | <input type="checkbox"/> S100 |
| <input type="checkbox"/> CAM 5.2 (CK 8/18) | <input type="checkbox"/> D2-40 (PODOPLANIN) | <input type="checkbox"/> MITF (Microphthalmia transcription factor) | <input type="checkbox"/> SALL4 |
| <input type="checkbox"/> Carbonic Anhydrase IX (CA9) | <input type="checkbox"/> Desmin | <input type="checkbox"/> MLH1 | <input type="checkbox"/> Serotonin |
| <input type="checkbox"/> CA125 | <input type="checkbox"/> DOG1 | <input type="checkbox"/> MSH2 | <input type="checkbox"/> Smooth Muscle Actin (SMA) |
| <input type="checkbox"/> CD1a | <input type="checkbox"/> DPC4 (SMAD4) | <input type="checkbox"/> MSH6 | <input type="checkbox"/> SMMHC (Smooth Muscle SMM) |
| <input type="checkbox"/> CD2 | <input type="checkbox"/> Epstein Barr Virus EBV | <input type="checkbox"/> Muc 2 | <input type="checkbox"/> SOX 10 |
| <input type="checkbox"/> CD3 | <input type="checkbox"/> E-Cadherin | <input type="checkbox"/> MUM1 | <input type="checkbox"/> Synaptophysin |
| <input type="checkbox"/> CD3 (T cell) | <input type="checkbox"/> EGFR | <input type="checkbox"/> MURAMIDASE (lysozyme) | <input type="checkbox"/> Terminal Deoxy Nucleo Tidyal (TDT) |
| <input type="checkbox"/> CD5 | <input type="checkbox"/> EMA | <input type="checkbox"/> Muscle Specific Actin | <input type="checkbox"/> TTF-1 |
| <input type="checkbox"/> CD7 | <input type="checkbox"/> EP-CAM (MOC 31) | <input type="checkbox"/> Myeloperoxidase | <input type="checkbox"/> Treponema Pallidum (spirochete) |
| <input type="checkbox"/> CD8 | <input type="checkbox"/> ER | <input type="checkbox"/> Myf-4 | <input type="checkbox"/> Thrombomodulin |
| <input type="checkbox"/> CD10 | <input type="checkbox"/> ERG | <input type="checkbox"/> MyoD1 | <input type="checkbox"/> Thyroglobulin |
| <input type="checkbox"/> CD14 | <input type="checkbox"/> Factor 13a | <input type="checkbox"/> Myogenin | <input type="checkbox"/> TRICHROME (BLUE) |
| <input type="checkbox"/> CD15 | <input type="checkbox"/> Factor VIII (Von Willebrand Factor [VWF]) | <input type="checkbox"/> Myoglobin | <input type="checkbox"/> TRICHROME (GREEN) |
| <input type="checkbox"/> CD19 | <input type="checkbox"/> Fascin | <input type="checkbox"/> MYOSIN SMOOTH MUSCLE SPECIFIC | <input type="checkbox"/> Tyrosinase |
| <input type="checkbox"/> CD20 | <input type="checkbox"/> FEULGEN | <input type="checkbox"/> Naspin A | <input type="checkbox"/> Tryptase (Mast Cell Tryptase - MCT) |
| <input type="checkbox"/> CD21 | <input type="checkbox"/> Fite | <input type="checkbox"/> NKX3.1 | <input type="checkbox"/> UROPLAKIN II |
| <input type="checkbox"/> CD23 | <input type="checkbox"/> Galectin-3 | <input type="checkbox"/> NSE | <input type="checkbox"/> Vimentin |
| <input type="checkbox"/> CD30 | <input type="checkbox"/> Gastrin | <input type="checkbox"/> OCT (2) | <input type="checkbox"/> Villin |
| <input type="checkbox"/> CD31 | <input type="checkbox"/> GATA-3 | <input type="checkbox"/> OCT (3/4) | <input type="checkbox"/> VWF |
| <input type="checkbox"/> CD33 | <input type="checkbox"/> GCDFP 15 | <input type="checkbox"/> P16 | <input type="checkbox"/> WTF 1 (Wilm's Tumor) |
| <input type="checkbox"/> CD34 | <input type="checkbox"/> GFAP | <input type="checkbox"/> P40 | <input type="checkbox"/> ZAP 70 |
| <input type="checkbox"/> CD35 | <input type="checkbox"/> GLUT-1 | <input type="checkbox"/> P504S (AMACR) | |
| <input type="checkbox"/> CD43 | <input type="checkbox"/> GLYPICAN3 | <input type="checkbox"/> P53 | |
| <input type="checkbox"/> CD44 | <input type="checkbox"/> Glycophorin A | <input type="checkbox"/> P63 | |
| <input type="checkbox"/> CD45/LCA | <input type="checkbox"/> GMS | <input type="checkbox"/> P120 (CATENIN) | |
| <input type="checkbox"/> CD56 | <input type="checkbox"/> GMS | <input type="checkbox"/> PAS | |
| <input type="checkbox"/> CD57 | <input type="checkbox"/> Gram (- / +) | <input type="checkbox"/> PAS + Distase (PAS-D) | |
| <input type="checkbox"/> CD68 KP1 | <input type="checkbox"/> Hepatocyte Specific Antigen (Hep-Par1) | <input type="checkbox"/> PAS W/ FUNGUS | |
| <input type="checkbox"/> CD68 PGM1 | <input type="checkbox"/> HBME | | |
| | <input type="checkbox"/> HCG | | |

PATIENT INFORMATION

SS#	DATE OF BIRTH	M <input type="checkbox"/>
		F <input type="checkbox"/>
		SEX

LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP

()

TEL # CHART # PATH#

PATIENT'S PRIMARY INSURANCE *ATTACH COPY OF INSURANCE CARD

BILL TO: MEDICARE PATIENT OTHER NO FAULT WORKERS COMP

INSURED'S NAME D.O.B. / /

DATE OF ACCIDENT (if NO FAULT/WORKERS COMP) / /

PT RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

POLICY # SS# - -

GROUP NAME: REFERRAL#

NAME OF INSURANCE CO:

*INSURANCE ADDRESS:

CITY STATE ZIP

PROSTATE BIOPSY:

of Cores _____

OTHER: _____