MMUH Cellular Pathology External Test Request Form

Please fill out all areas & send report (including clinical details) with all requests

Patient Details		Hospital & Sample Information	
Forename:		**Referring Hospital:**	
Surname:		**Requesting Consultant:**	
External Hospital Number:		**Contact Phone No:**	
DOB:		**Contact Email address:**	
Gender (M/F):		**Slide(s) &/or Block(s) Details:** • **Include nature of specimen** • **Include <u>REPORT</u> with all requests**	
Address:			

Tests Required		
IHC/ISH/Molecular	**Specials**	**Other**

On return of completed tests please contact MMUH by FAX (01-8032251) or EMAIL: historeception@mater.ie, to confirm receipt

MMUH Cellular Pathology Use Only			
Date & Time received:		**Slide(s) &/or Block(s) received:**	
Report received	YES ☐ NO: ☐		
MMUH Laboratory No. assigned:		**HPROE Entered?**	YES: ☐
		Topography code:	CODE:
		Senior Checked?	YES: ☐ Initial:

MMUH Return procedure: {Required ☐} {Not applicable ☐}			
'Macro' entered?	YES ☐	**'Micro' Entered?**	YES ☐
Reported Final on 'MGR' System?	YES ☐	**aWay' Completed?**	YES ☐
Returned Slide/ Block Check:	YES ☐ Date:	**Reported in MMUH by:**	Date:

		Confirmation of return to source?	YES ☐ Email: ☐
Despatch: (Initial)	Delivered by:		Fax: ☐
	Accepted by:		Initial: