Molecular Pathology Center, CUISSS Centre-Ouest/Jewish General Hospital
Tel.:(514) 340-8222 # 3120 (molecular pathology) or #8427 (for PD-L1), Fax: (514) 340-8134

Hôpital général juif
Jewish General Hospital
Centre de pathologie moléculaire

Requisition for Molecular Pathology

SOLID TUMOURS

Requesting physician:

Name : Dr. _____
Institution: _____
Department: _____
Address: _____
City, postal code: _____
Tel: (___) _____-_____
Fax: (___) _____-_____
The fax number is mandatory and will be use dot send the results

Copy to: Dr. _____
Fax: (____) _____ - _____
Dr. _____
Fax: (____) _____ - _____

Patient:

Name: _____
Given name: _____
D.O.B.: _____/____/____ (yyyy/mm/dd)
Sex: ❑ M ❑ F
JGH registration #: _____
RAMQ #: _____

Sample

Date of procedure: _____/____/____ (yyyy/mm/dd)
Hospital of procedure, city:_____,_____

❑ Paraffin block (including cell block)
Block ID #: _____

Site: ❑ Colon ❑ Rectal ❑ Lung, right ❑ Lung, left ❑ Skin ❑ Lymph node Other: _____

Type of specimen: ❑ Surgical resection ❑ Biopsy, core biopsy ❑ Fine Needle Aspiration ❑ EBUS
❑ Other: _____

❑ Cytological fluid ❑ Fluid ID #: _____

Type of fluid: ❑ Pleural ❑ Pericardial ❑ Other: _____

❑ Other Sample ID #: _____ Sample type: _____

Test Requested

❑ *RAS (*K and N*)* mutation analysis

❑ *BRAF* mutation analysis

❑ *EGFR* mutation analysis (incl. T790M) + ALK rearrangement

❑ *EGFR T790M* analysis (without ALK)

❑ *ALK* rearrangement

❑ *MLH1* promoter methylation analysis

❑ MSI analysis: Tumor sample, block ID#: _____
Normal tissue, block ID#: _____

❑ PD-L1 immuno-expression (clone 22C3, NSCLC only)

❑ Other: _____

Include the original pathology report with this requisition for all test requests.

Send request and samples to: **Jewish General Hospital Pathology, Room G102 3755 Cote St Catherine Road Montreal, QC H3T 1E2**	Physician's signature:	Date of request: _____/____/_____ (yyyy / mm / dd)

Samples received without this requisition form will **NOT** be processed