Advance Histopathology Laboratory Ltd

47a Devonshire Street, W1G 7AW
specimen@ahlab.co.uk

020 7636 9447 020 7636 9929 07860821252 www.ahlab.co.uk

TITLE	MR ☐ MRS ☐ MS ☐ MISS ☐ DR ☐ OTHER ☐
FORENAME	
FAMILY NAME	
DOB									SEX: M ☐ F ☐
PATIENT ADDRESS	
HOSPITAL NO. / REFERENCE	

CLINICAL DETAILS **Risk of Infection: No ☐ Yes ☐**

SAMPLE TYPE

Requesting Physician/Surgeon (print name):

Date & time of sample:

Hospital:

Contact:

Report email ☐ ________________________

Report Fax ☐ __________________________

Report paper copy ☐

Invoice

Hospital ☐ Doctor ☐ Other ☐

Patient ☐ (contact details mandatory)

Contact:

Insurance ☐ (Patient address mandatory)

Policy No: ______________________________

Authorisation code: ______________________

Lab Use only.

LAB NO:

NO. OF SAMPLES:

SAMPLE DESCRIPTION:

V2 Jan 2019

TRIAGE:

H+E / 3 levels / CFV / ABPAS / PAS

DISSECTION:

NO. BLOCKS:

ALL TAKEN: YES / NO

RESERVE: 1 / 2 / AFOS / KEEP

DECAL
DATE IN:
DATE OUT:

EMBEDDED:

MICROTOMY:

H&E QC:

EXTRA REQUEST:

EXTRA MICROTOMY:

EXTRA QC: