

Patient name			
MHN	DOB	Age	Gender

-- Not a medical record document --

Surgical Pathology Specimen Request

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Marshfield Clinic Requesting Provider Information

Requesting provider	
Contact name	Contact phone number

Facility and Case Information

Original facility name	
Surgery date	Surgical case number
ICD code	

Test(s) to be Ordered (check all required)

<input type="checkbox"/> ALK rearrangement by FISH (ALKRESO)	<input type="checkbox"/> Hydatidiform mole eval (HYDATSO)
<input type="checkbox"/> BRAF, melanoma V600E analysis (BRAFMEL)	<input type="checkbox"/> KRAS mutation analysis (KRAS)
<input type="checkbox"/> BRAF, other V600E analysis (BRAFOH)	<input type="checkbox"/> NRAS mutation analysis (NRASSO)
<input type="checkbox"/> EGFR mutation analysis in NSCLC (EGFRPSO)	<input type="checkbox"/> ROS-1 by FISH (FROS1SO)
<input type="checkbox"/> Non-coded test (MISCTIS) Specify test name _____	
<input type="checkbox"/> Full pathology review (with report issued)	

Requested Material (send with sample):

- Copy of surgical pathology report
- All H & E slides associated with the case
- All paraffin blocks associated with the case
- Copy of this request

Send Requested Samples to:

Marshfield Labs
 Attention: Histology DNA Lab
 701 West Kalsched Street
 Marshfield, WI 54449

Marshfield Labs will return all blocks and slides to your facility after testing.

Contact Marshfield Lab's Histology Department at 1-800-222-5835, ext. 1-6186 with any questions.

Signature/Title _____ Date (m/d/y) ____ / ____ / ____

LAB USE ONLY

Date received (month/day/year)	Date sent out (month/day/year)	Date result received (month/day/year)	Date reported (month/day/year)
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