



Name:		DOB (dd/mm/yyyy):	
Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tel:	
Referring Doctor:			
Relevant Clinical History:			
Pathology Request Form			
Histopathology			
<input type="checkbox"/>	Endoscopic Biopsy	<input type="checkbox"/>	Tissue Biopsy
<input type="checkbox"/>	TAH & BSO	<input type="checkbox"/>	Bone Marrow Aspiration Cytology
<input type="checkbox"/>	Bone Marrow Trepine Biopsy	<input type="checkbox"/>	FNAC
<input type="checkbox"/>	Conventional PAP	<input type="checkbox"/>	Thin Prep PAP Test
IHC Pannel			
<input type="checkbox"/>	LCA & EMA	<input type="checkbox"/>	Myeloid Leukemia (CD 13, 117)
<input type="checkbox"/>	Lymphoid Leukemia(CD 3,5,10,19,20)	<input type="checkbox"/>	Myeloma (CD 138, κ, λ)
<input type="checkbox"/>	CA Breast (ER, PR, HER 2)	<input type="checkbox"/>	CA Lungs (CD 56, EMA, Chromogranin, Synaptophysin)
<input type="checkbox"/>	Colorectal Markers (CEA,Ki67,VEGF)	<input type="checkbox"/>	CA Stomach/GIST (LCA,EMA CD117)
<input type="checkbox"/>	Urinary Bladder (P53, Cyclind1, Cytokeratin20)	<input type="checkbox"/>	Soft Tissue Tumor (Anti-Desmin)
<input type="checkbox"/>	Neural Tumors (NSE, Chromogranin, Synaptophysin)	<input type="checkbox"/>	
Fluid RE & Cytology			
<input type="checkbox"/>	Pleural Fluid	<input type="checkbox"/>	CSF
<input type="checkbox"/>	Ascites Fluid	<input type="checkbox"/>	Synovial Fluid
<input type="checkbox"/>	Sputum	<input type="checkbox"/>	
Other Tests		Doctor's Name: Address:	
Call Us: 09 782019100 for Test Information, 09 43130225 for Home Service, 09 43067103 for Tube Collection Team.			