

SAMPLE REQUEST FORM

Patient Details

Patient Name:

Facility:

Phone:

Date of Birth: (mm/dd/yyyy)

Gender: Male Female

Medical Record #:

Specimen/Block ID #:

Requester Details

Name:

Organization:

Address 1:

Address 2:

Phone:

Collection Information

Collection Date: (mm/dd/yyyy)

Collection Time: (hh/mm)

Sample details:

Urgency: Normal **URGENT**

Sample Type: FFPE Tissue Blood
 Bone Marrow Cytology
 Other, specify:
