



Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient ID (Medical Record Number, if available)		
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact <i>(Last, First)</i>	Phone	Fax*

*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

Reason for Testing

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Reviewing Case

Number of Unstained Slides Submitted	Pathology Report Included <input type="checkbox"/> Yes <input type="checkbox"/> No	Collection Date <i>(mm-dd-yyyy)</i>
Fixative Used <input type="checkbox"/> Formalin <input type="checkbox"/> Bouins <input type="checkbox"/> Prefer <input type="checkbox"/> Other: _____		
Reviewing Pathologist Name <i>(Last, First)</i>		Date <i>(mm-dd-yyyy)</i>
Primary Tumor (site) <input type="checkbox"/> Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Gastroesophageal <input type="checkbox"/> Urothelial <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Metastatic Tumors (indicate site of metastasis, if known) <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Lymph node <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Skin <input type="checkbox"/> Bone: Decalcified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	
Breast Morphology Descriptor Only <input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mucinous <input type="checkbox"/> Papillary Circled Area <input type="checkbox"/> Invasive tumor only <input type="checkbox"/> Metastatic tumor only <input type="checkbox"/> Invasive _____ % plus DCIS/LCIS _____ % circled <input type="checkbox"/> DCIS/LCIS present – not circled _____ % <input type="checkbox"/> IN SITU ONLY <input type="checkbox"/> Other: _____	Gastroesophageal Descriptor Only Morphology: <input type="checkbox"/> Glandular <input type="checkbox"/> Single cell invasion _____ % invasive vs. noninvasive tumor (dysplasia) circled Miscellaneous <input type="checkbox"/> Poor fixation/Morphology <input type="checkbox"/> Less than 100 tumor cells <input type="checkbox"/> Other: _____	

Pathologist Notes (other pertinent information)

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Mayo Cytogenetics Use Only

<input type="checkbox"/> Cancel – lab will order full study <input type="checkbox"/> FHER2 <input type="checkbox"/> FH2GE <input type="checkbox"/> FH2UR <input type="checkbox"/> FH2MT Trigger <input type="checkbox"/> Only block received <input type="checkbox"/> Unmarked H&E <input type="checkbox"/> Equivocal result <input type="checkbox"/> Heterogeneity <input type="checkbox"/> HER2 amped outside circled area <input type="checkbox"/> Difficulty identifying invasive tumor for FISH scoring, requiring consultation with a pathologist
