Tel: Enquiries 020 7608 6948
Laboratory 020 7608 6888
Fax: 020 7608 6862

DEPARTMENT OF EYE PATHOLOGY
UCL Institute of Ophthalmology
11-43 Bath Street, London EC1V 9EL

HISTOPATHOLOGY/CYTOLOGY REQUEST

NHS Number:

Hospital Number:

HIGH RISK Specimen ☐
(Tick: *Re ACDP Classification)*

ETHNIC ORIGIN:

Lab No: *(Lab use only)*

Date & Time of Receipt: *(Lab use only)*

SURNAME (Block Capitals):

CATEGORY: NHS ☐
*** PRIVATE** ☐
(signed letterhead required)*

For Office Use:
Banding | **Pots**

REQUESTING LOCATION
HOSPITAL

FORENAMES:

RESEARCH CONSENT: Y / N

ADDRESS
(for report)

DATE OF BIRTH: D D M M Y Y Y Y

SEX: M ☐ F ☐

COLLECTION DATE & TIME:
...../...../..... ..... : .....

CONSULTANT

PLEASE NOTE: INADEQUATELY COMPLETED REQUEST FORMS MAY NOT BE PROCESSED

NATURE OF SPECIMEN(S):

SITE:

LEFT ☐ **FIXED** ☐
RIGHT ☐ **FRESH** ☐

CLINICAL DETAILS: *(Previous Histology Reference Number, if any):*
Please state if specific question is to be addressed:

Clinical photograph available? Y/N Clinic return date: ...../...../.....

CLINICIAN'S SIGNATURE:

PRINT NAME:

Tel/Pager:

If urgent – required by date:

For Laboratory Use Only:

Affix Lab No here:

Pathologist request:

Cut up:

No of blocks:

Embedded:

Initial cutting:

Checked H&E:

Extra Request:

Extras cut:

Extras checked: