



## Immunohistochemistry Requisition – Tech Only      Case # \_\_\_\_\_

University of Mississippi Medical Center Immunohistochemistry Lab 2500 N State Street, Jackson, MS 39216 Phone: 601-815-9824	<b>CLIENT:</b> Baptist Medical Center Jackson 1225 N State Street Jackson, MS 39202 Phone: 601-968-3070 Record # 212 Client Bill, Only
---	--

**Billing Information: Bill To: Client**

<b>Patient Information</b>		
Last Name	First Name	Middle Initial
Date of Birth	Medical Record Number	Gender
	Billing Number	

<b>Ordering Pathologist (please print)</b>	
Last Name	First Name
<b>Authorized Pathologist Signature</b>	Date

<b>Specimen Information</b>	
Collection Date and Time	Number of Specimens Sent:
	Unstained Slides:      From Block #:
Clinical Diagnosis (if available)	Pathology Working Diagnosis/Differential Diagnosis

Comments:
-----------

<b>Immunostain Requested (Check box to the left of stain you are ordering)</b>			
<input type="checkbox"/>	CD1A	<input type="checkbox"/>	EBV/LMI-ASR
<input type="checkbox"/>	CD4	<input type="checkbox"/>	GATA-3
<input type="checkbox"/>	CD56	<input type="checkbox"/>	GCDFP15
<input type="checkbox"/>	CD68	<input type="checkbox"/>	HHV8
<input type="checkbox"/>	CD7	<input type="checkbox"/>	HSV I&II-ASR
<input type="checkbox"/>	CD8	<input type="checkbox"/>	IGG4
<input type="checkbox"/>	CMV-ASR	<input type="checkbox"/>	MLH1
<input type="checkbox"/>	D2-40	<input type="checkbox"/>	MSH2
<input type="checkbox"/>	DOG1	<input type="checkbox"/>	MSH6
		<input type="checkbox"/>	P40
		<input type="checkbox"/>	PAX-8
		<input type="checkbox"/>	PMS2
		<input type="checkbox"/>	SOX-10
		<input type="checkbox"/>	WT-1
		<input type="checkbox"/>	MMR Panel (MLH1, MSH2, MSH6, PMS2)
		<input type="checkbox"/>	Other

Delivered by: \_\_\_\_\_

Received by: \_\_\_\_\_

Received by IHC Lab: \_\_\_\_\_

Picked up by: \_\_\_\_\_

Date and Time: \_\_\_\_\_

Date and Time: \_\_\_\_\_

Date and Time: \_\_\_\_\_

Date and Time: \_\_\_\_\_