

Patient Information		
Family Name:		
First Name:		Date of Birth:
Address:		
Email:		

Priv. Doz. Dr. med. S. EIDT
Dr. med. R. HAKE

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Order Form - Molecular Pathology Analysis

Orderer* / Invoice Adress:
* most probably Self-Pay Patient

Specific Request Details: _____

Provided Material: 2 Slices (5-10 µM) in 1,5 mL plastic tubes
 + 1 HE Stain + 1 unstained tissue slice on glass slide

FFPE Block external number: _____

Histopathologic Results:	Requested molecular Analysis	
Tumor Size: _____	STRATIFYER Test	STRATIFYER Test
Grading: _____	MammaTYPER: <input type="checkbox"/>	LungTYPER: <input type="checkbox"/>
Histological Type: <input type="checkbox"/> ductal	ProliferationTYPER: <input type="checkbox"/>	NET TYPER: <input type="checkbox"/>
<input type="checkbox"/> lobular	ImmuneTYPER: <input type="checkbox"/>	17q12 TYPER: <input type="checkbox"/>
<input type="checkbox"/> tubular	CheckPointTYPER: <input type="checkbox"/>	Mutation TYPER: <input type="checkbox"/>
<input type="checkbox"/> other	BladderTYPER: <input type="checkbox"/>	(KRAS, BRAF, ALK)

DCIS-Component: <input type="checkbox"/> yes <input type="checkbox"/> no
Lymph node status: <input type="checkbox"/> tumor free <input type="checkbox"/> LN-metastasis: pN <input type="checkbox"/> not examined
Thyroid gland status: <input type="checkbox"/> Hashimoto <input type="checkbox"/> Hyperfunction <input type="checkbox"/> Hypofunction

internal Result	Tumor heterogeneity: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> in-situ component
	Inflammation: <input type="checkbox"/> yes <input type="checkbox"/> no
	Others: _____

 Date, Signature of Orderer