MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Colorectal Cancer MMR Biomarker Immunohistochemistry Testing Requisition

PATIENT INFORMATION:

Name (Last, First): _____

Date of Birth: _____ **Gender (M/F):** _____

Health Card Number: _____
(include version code)

Clinical Information: _____

TEST REQUESTED:

☐ **Colorectal Cancer Mismatch Repair (MMR) testing by immunohistochemistry**

SPECIMEN INFORMATION:

Referral Specimen ID: _____

Material Sent: 1. BLOCK(S) ID: _____
2. PATHOLOGY REPORT

REFERRING PHYSICIAN/INSTITUTION INFORMATION:

Referring Physician Name (Last, First): _____

Institution Name and Address: _____

_____

Phone: _____ Fax: _____

SHIPPING/CONTACT INFORMATION:

Send specimen and completed requisition to: Michael Garron Hospital, Pathology Department
825 Coxwell Avenue
H wing, 2nd floor, room 203
Toronto, ON, M4C 3E7
Phone: 416-469-6360
Fax: 416-469-6359
Email: PathologyOffice@tehn.ca

MGH Laboratory Use Only:
Date Received: _____ Tech Initials: _____ MGH Accession #:_____