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| --- | --- | --- | --- |
| **PD-L1 IHC Request Form**  **UROTHELIAL CARCINOMA** | | | |
| **Referring Laboratory** | |  | |
| **Referring Lab Specimen Number** | |  | |
| **Date of Request** | |  | |
| **Contact Name & Number** | |  | |
|  | | | |
| **Patient Details:** | | | |
| **First Name** | |  | |
| **Surname** | |  | |
| **Date of Birth** | |  | |
| **MRN** | |  | |
|  | | | |
| **Requesting Clinician + email address** | | |  |
| **Requesting Pathologist + email address** | | |  |
|  | | | |
|  | | | |
| **DRUG** |  | | |
| **Pembrolizumab** |  | | |
| **Atezolizumab** |  | | |

**Comment: Please ensure one drug is selected- if none is ticked, all material will be returned and not tested.**

**Reflex testing will be carried out with a second antibody if the first one tested is negative.**

***Please send 4 unstained sections + H&E + corresponding tissue block***

***+ histopathology report***

*To Histopathology Department*

*St Vincent’s University Hospital*

*Elm Park*

*Dublin 4*

*Enquiries: 01-2214797*

*Contact email: histolab@svhg.ie*