

Request for In Situ Hybridization (ISH) Analysis

(Please complete top portion of form and attach labeled envelope with unstained charged slides. Submit to Room 2N113.)

PATIENT NAME: _____ (Last, First)		DATE REQ: _____
NIH SURGICAL PATH NUMBER: _____		PRIORITY: Rush <input type="checkbox"/> Routine <input type="checkbox"/>
No. OF SLIDES: _____	OUTSIDE LABEL: _____	TISSUE SOURCE: _____
PURPOSE: Clinical: <input type="checkbox"/>		Clinical Question: _____
Research: <input type="checkbox"/>		Project Title: _____
BRIEF HISTORY: _____ _____		
TESTS OFFERED (Please indicate number of slides per test):		
(1) EBV	_____	Specify Other: _____
(2) U6	_____	
(3) Other	_____	
REQUESTED BY: _____		ROOM: _____

(For laboratory use only)

Labeled Probe Lot#: E/ _____ U/ _____

EBER CTRL filed with case: _____

	Adequate	Inadequate
EBER Control		
U6 Case Control		

Comments:

EBER Rating (0-4):

(positive cells per high power field)

- 0 = negative
- 1 = <1
- 2 = 1-5
- 3 = 5-15
- 4 = >15

TAT (days): _____

Run Date: _____

Tech. Initial: _____

Attending Initial: _____

ISH No.: _____