Requestor Information: (* fields are mandatory)

*Name: ______________________ *Address: ______________________

Requesting on behalf of (If applicable): ______________________

*Institution: ______________________

*Department: ______________________

*Email: ______________________

*Phone: ______________________

*Fax: ______________________

Billing information: ☐check if same as above

*Name: ______________________

*Institution: ______________________

*Address: ______________________

*Email: ______________________

*Phone: ______________________

Shipping information: ☐ check if same as above

*Name: ______________________

*Institution: ______________________

*Address: ______________________

*Courier Company: ______________________

*Account Number: ______________________

Indicate the Reason for Request : ☐ Patient Care______________________

(standard of care)

Fees Apply (•):

•☐ Patient Care______________________ *(above standard of care. e.g. out of province second opinion)*

•☐ Medico-Legal______________________

•☐ Education______________________

•☐ Research______________________

•☐ Clinical Trial______________________

•☐ Other ______________________

Checklist:

For ALL requests, please submit

1. A completed Supplemental Information form for Diagnostic Materials Requests.
2. Patient authorization for release of materials with his/her identifiable personal health information on it (e.g. pathology identification number, MRN, name, date of birth...etc...).

For Research/Clinical Trial Requests, please ALSO attach the following:

3. A copy of the research protocol (If a confidential agreement prevents the release of the protocol in total, then please provide all relevant sections pertaining to the tissue request)
4. REB/IRB approval letter

Material Requested (Please note that LMP does not release blocks/ cores):

☐ Digital Scans of original slides: specify case number(s) ______________________

☐ Unstained slides: specify case number(s) ______________________

☐ Recut stained slides: specify case number(s) ______________________

☐ Other: case number(s) ______________________

Case/Patient info:

*Case number(s) if known: ______________________

*Patient MRN: ______________________

*Patient Name: ______________________

*Patient DOB: ______________________

Requestor Name:______________________ Signature:______________________ ***Date***:______________________

(Print First Name and Last Name)

Please allow two to four weeks for requests to be completed upon receipt of ALL required documentation.

LMP will only release the amount of tissue required for the specific testing indicated in the supplemental information form.