Intrahepatic and Perihilar Cholangiocarcinoma and Hepatocellular Carcinoma
Histopathology Request Information

Family name

Given name(s)

Date of birth

DD – MM – YYYY

Date of request

DD – MM – YYYY

Ethnicity

- ○ Unknown
- ○ Aboriginal/Torres Strait Islander (AU)
- ○ Māori (NZ)
- ○ Other ethnicity:

Patient identifiers
e.g. MRN, IHI or NHI (please indicate which)

Requesting doctor - name and contact details

Copy to doctor
name and contact details

RADIOLOGICAL/IMAGING INFORMATION

OPERATIVE PROCEDURE

NEW PRIMARY LESION OR RECURRENCE

- ○ New primary
- ○ Recurrence - regional, *describe*
- ○ Recurrence - distant, *describe*

PRINCIPAL CLINICIAN

OTHER COMMENTS