Arkana Laboratories

Stain / Second Opinion Requisition Form

Affix patient sticker here

Collection Date: ____________ **Surgical Number:** ____________

Patient Information:

Patient Name: ____________ Date of Birth (MMDDYYYY): ____________ Gender: ☐ M ☐ F

Referring Facility:

Facility Name: ____________ Phone #: ____________ Fax #: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Billing Contact: ____________ Billing Contact Phone #: ____________

Billing Contact Email Address: ____________

Requested testing:	**Material / Slides Required:**
☐ Membranous Panel 1 (PLA2R, THSD7A, NELL1)	paraffin / 7
☐ Membranous Panel 2 (EXT1, NCAM)	paraffin / 5
☐ Paraffin IF	paraffin / 8
☐ C4D (IHC)	paraffin / 3
☐ LRP2	paraffin / 3
☐ SAP	paraffin / 3
☐ DNAJB9	paraffin / 3
☐ Myoglobin/ Hemoglobin	paraffin / 4
☐ Alports panel- Collagen II & V	frozen / 3
☐ IgG subclasses (1-4)	frozen / 5
☐ Second Opinion	

*Please send relevant slides and report

***This includes technical and professional interpretation. A report will be faxed within 48 hours upon receipt of specimen.**

10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com