

CORE DIAGNOSTICS™

Test Requisition Form

TRF No.: 1080714

Accessioning ID
01st August 2024

PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Date of Birth / Age: 18Y/M
 Gender: Male Female
 First Name: Mr. R. Susil Weddikara
 Last Name: Colombo - Sri Lanka
 Address: _____
 PIN Code: _____
 Contact Number: _____
 Email ID: _____

Do you want us to send report & block at above given address? Yes No

Do you want us to send report at above given email-id? Yes No

If No, please specify: _____

PHYSICIAN INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Name: Dr. Wasantha Rathnayake
 Speciality: Consultant Clinical Oncology
 Address: _____
 PIN Code: _____
 Contact Number: _____
 Email ID: _____
 Hospital / Institution Name: _____
 Institution Code: IN10392

PHYSICIAN CONSENT

I certify that the patient has been informed of the benefits, risks, and limitations of the tests requested, informed the patient of the availability of genetic counselling, and have obtained informed consent from the patient for the tests requested.

Signature and Stamp of the Physician

PATIENT HISTORY (TO BE FILLED IN CAPITAL LETTERS ONLY)

Clinical History Attached Yes No
 History of Smoking Yes No
 Past History of Cancer Yes No
 Diabetes Yes No
 Drug Intake if Any Yes No
 If any, Name of the Drug _____ Amount and Time of Dose _____
 Radiological / Endoscopic findings: _____
 Other Relevant History: _____
 Repeat Sample, If Yes, Please share old case number: _____

FOR GYNECOLOGICAL CYTOLOGY

Previous Cytology / PAP Reports Yes _____ No _____
 Last Menstrual Period (LMP) _____
 Details of Hormonal Status _____
 Details of Hormonal Therapy _____
 Details of Contraception _____
 Details of Previous Surgery _____

PATIENT CONSENT

My healthcare provider has provided me with information regarding the tests requested on this form and advised me of the availability of professional genetic counselling. I confirm that the details provided on the form are correct and I have been informed of the benefits, risks, and limitations of the tests requested. I understand the implications of the information provided on the TRF on the test results. I have read and am aware of the conditions of reporting mentioned on the TRF. I give my consent that upon completion of the test, the remaining sample and test data may be "de-identified" and CORE Diagnostics may use this sample and test data for quality improvement, and/or research studies.

Signature/Thumb Impression of Patient

MODE OF PAYMENT (TO BE FILLED IN CAPITAL LETTERS ONLY)

Cash Cheque DD
 Credit / Debit Card NEFT / RTGS Client Billing

For Client Billing:

Client Name: Aegle Omics Private Limited

Client Code: CL02611

For Others:

Transaction ID/Receipt No.: _____

Amount Paid: _____

TEST REQUIRED (TO BE FILLED IN CAPITAL LETTERS ONLY)

Test Code	Test Name
MM1101	IDH 1 & 2 Mutation Analysis
YB1104	1p/19q (co-deletion)
	Formalin fixed paraffin embedded tissue block
	Wax Block 1 - 01-361 10/07/24
	GJ4788A,d

SPECIMEN DETAILS

Specimen Type	No.	Specimen Type	No.
FFPE Block	S1	Aspirate Material	S13
Whole Blood EDTA / ACD / Fluoride / Heparin / Sodium Citrate	S2	Plasma EDTA/ Fluoride / Citrate	S14
Urine 1st Morning / Random Urine / 24 hrs Urine	S3	10% Buffered Formalin / Saline / Michel's media / Glutaraldehyde	S19
Cervical Scraping	S5	Bone Marrow Aspirate and Smear	S16
3-4 ml Bone Marrow / Peripheral Blood in EDTA	S6	Bone Marrow Biopsy	S17
3-4 ml Bone Marrow / Peripheral Blood in Sodium Heparin Tube	S7	Bone Marrow Aspirate / Biopsy	S18
10% Neutralised Buffered Formalin	S8	2 ml Serum from SST Tube	S15
7-10 ml Maternal Blood	S9	Fine Needle Aspirate	S20
Buccal Swab	S10	Sputum	S21
Biopsy Small / Medium / Large / Radical	S4	Stool	S22
Stained Histopathology Slides	S11	Bronchoalveolar Lavage (BAL)	S23
Body Fluids	S12	Others	S24

Bar Code	Specimen No.	Qty.	Identification No	Source Type
A.				
B.				
C.				
D.				
E.				

COLLECTION DETAILS (FOR OFFICE USE ONLY)

Collection Date: _____ Collection Time: _____
 Temperature at shipping: Ambient Refrigerated Frozen
 Collection at: Hospital Lab Patient Home Walk in Others
 Collection Address: _____
 Collection ID: _____ POD _____

PHLEBOTOMIST INFORMATION (FOR OFFICE USE ONLY)

Name: _____ COREwings
 Sign: _____ Barcode

ACCESSIONING DETAILS (FOR OFFICE USE ONLY)

To be filled by the Accessioning Officer (Mandatory)
 Receiving Person: _____
 Sign: _____ Date: _____ Time _____
 Number of Samples: _____
 Type of Sample _____
 Receiving Temperature: Ambient Refrigerated Frozen

PATIENT/PHYSICIAN RECEIPT

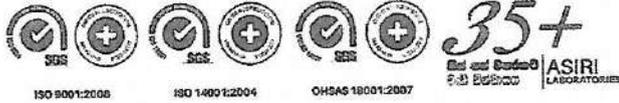
Patient Name: _____
 # of Samples Submitted: _____
 Date of Submission: _____
 Helpline No. : +91 88828 99999
 Bangalore Lab : +91 8022244777 | Delhi Lab : +91 11 46269604

Date of Birth/Age: _____ TRF No: 1080714
 Test Name and Test Code: _____



CONFIDENTIAL LABORATORY REPORT

Member of Clinical and Laboratory Standards Institute, U.S.A.



Central Hospital Limited. No. 114, Norris Canal Road, Colombo 10.
T. +94 11 466 5500 F. +94 11 466 5599 chllab@asiri.lk

Block and slides of this specimen/s will be retained ONLY for six months after the date of this report. Specimen will be kept for one week

HISTOPATHOLOGY

** IP/CHL/ACH ** Page 1 of 1

UHID : 110197716
 REFERENCE No. : 02 4177 09/07/24 IP No. : CHB0011720
 SAMPLE DATE & TIME : 09/07/2024 16:56 AGE : 78 Y/M
 REPORT DATE & TIME : 24/07/2024 17:15 AHH2099903 / ACH2205885
 PATIENT : MR. R SUSIL WEDDIKKARA [ROOM NO.1034A]
 REFERRED BY : DR SUNIL PERERA (NEURO SURGEON)

TEST : CYTOLOGY (FROZEN BIOPSY)

Frozen cytology / Brain smear

Right side temporal region.

Microscopy : Moderately cellular smears reveal proliferated glial cells in a focally fibrillary background. Nuclei are pleomorphic and round. Thin capillaries are seen in the stroma. Mitoses are not seen. Calcification is prominent. No necrosis.

Conclusion : * Cytomorphologically, inkeeping with glial tumour.
? High grade Oligo.

* Need histology to confirm the grading.

GJ

DR. GEETHIKA JAYAWEEERA
M.B.B.S., Dip. Path, M.D. (Histopath) FCPPathSL
Consultant Histopathologist



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HISTOPATHOLOGY

** OPD/AHH/ALS **

Page 1 of 2

REFERENCE No. : 01 0361 10/07/24
 SAMPLE DATE & TIME : 10/07/2024 11:44 AGE : 78 Y/M
 REPORT DATE & TIME : 24/07/2024 17:14 AHH2099903 / AHH8876
 PATIENT : MR. R SUSIL WEDDIKKARA (110197716) 4178/4180C
 REFERRED BY : DR.SUNIL PERERA

TEST : HISTOPATHOLOGY REPORT

Specimen : Right side superior temporal region SOL.
 MRI - 22/07/23 - Infarct or encephalitis
 28/07/23 - subacute infarct
 ? Neoplastic process
 ? Chronic small vessel ischemic changes.

Histology : 30/11/23 (LHD) reactive gliosis.
 Neuro degenerative condition.

Frozen : 09/07/24 - Glial tumour (Oligo)
 ? High grade.

Macroscopy : 1. Dura with attached tumour dura 6 x 4cm, tumour 3 x 2cm.
 Several fragments 3 x 2cm.
 Cut surface - gray white with haemorrhage.
 ? Necrotic/ yellowish.

2. Small fragments in aggregate 1 x 1cm.

Microscopy : 1. Highly cellular tumour composed of malignant glial cells in a focally fibrillary and microcystic background.
 Both oligo II and oligo III areas are seen.
 Glomeruloid type capillary endothelial proliferation is seen. More cellular areas show neoplastic glial cells with brisk mitotic activity. Palisaded necrosis is prominent together with geographical necrosis.
 Calcification is seen in some of the slides.
 Features of encephalitis is not seen. Organisms or fungal spores / hyphae are not seen in this biopsy.

2. Remaining from frozen. Sections reveal moderately cellular tumour composed of neoplastic glial cells. Stroma shows thin capillary proliferation. Calcification is seen. (Oligo features).



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HISTOPATHOLOGY

** OPD/AHH/ALS **

Page 2 of 2

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 REFERRED BY : DR.SUNIL PERERA

(Review previous slides WK 018917/ WK 018919
 cortical dyslamination is noted.
 (Benign focal cortical dysplasia - FCD)

Immunohistochemistry

GFAP - Neoplastic cells show strong diffuse positive staining.

Ki-67 - High proliferative activity is seen.
 Index > 70%.

Conclusion : Right side superior temporal region SOL

- * Immunohistochemistry supports the histological diagnosis of high grade glioma./ Glioblastoma (CNS WHO grade 4).
- * Recommend - Molecular assay IDH1, IDH2, 1P19q co-deletion.

GJH - 4788/89
 (S.C.T - 09/07/2024 at 06.30 pm)

DR. GEETHIKA JAYAWEERA
 M.B.B.S., Dip. Path, M.D. (Histopath) FCPATHSL
 Consultant Histopathologist

80



Commercial Bank Card Centre

AEGLE OMICS
NO 33 PARK STREET COLOMBO 03
DATE/TIME : 2024 07 27 11:09:14
MERCHANT ID: 708007090040880
TERMINAL ID: 33140780
BATCH NUM : 000009
INVOICE NUM: 000010
SALE
CARD NUM : 552474****2762 C
EXP DATE : ** **
CARD TYPE: Mastercard



27th July 2024,

Mr. Sunil Weddikkara
Colombo

Dear Sir,

QUOTATION FOR CONDUCTING GENETIC TESTING

As requested by Dr. Wasantha Rathnayake Clinical Oncologist, we are pleased to offer you the following services for Diagnostic purpose through Core Diagnostic Pvt. Ltd, India.

Financial Offer

Test Cord	Test Name	Cost for the Toal Package (LKR)
MM1101	IDH 1 & 2 Mutation Analysis	Rs. 243,840 /-
YB1104	1p/19q (co-deletion)	

- Diagnose results, reports will be given after 28 working days.
- Full payments should be transferred before the execution of the process.

Account Details.

Aegle Omics (Private) Limited
Bank - Commercial Bank
Branch- Narahenpita
Acc No- 1000756928
Swift Cord- CCEYLK LX

Thanking you!

.....
Amila Herath
Manager Operations

Patient Name	Mr. Sunil Weddikkara
Age	78 Y/M
Referral	Dr. Wasantha Rathnayaka
Organisation	Core Diagnostics
Invoice No	AO0036

Invoice

Date: 30th July 2024

#	Test Description		Amount
1	IDH 1 & 2 Mutation Analysis	LKR	243,840.00
2	1p/19q (co-deletion)		
	Total		243,840.00

Mode of Payment	Cash	Card	Bank Transfer
		LKR 243,840.00	LKR

Received Total Amount	LKR. 243,840.00
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Issuing Officer's signature