

CORE DIAGNOSTICS™

Test Requisition Form

15th July 2024

Accessioning ID

TRF No.: 1080714

PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Date of Birth / Age: 72Y/m
 Gender: Male Female
 First Name: Mr. R.A.D.G. Francis
 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. Mahendra Perera
 Speciality: Consultant Clinical Oncology & Radiotherapy
 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
NA3166	HRR Gene Panel (Germline) Extended
	3-4 mL Peripheral Blood in EDTA(Lavender Top), 2 Tubs

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: _____ 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: _____

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Dr. MAHENDRA PERERA
MBBS (Cey), MD (Col), Dip RT
Consultant in Clinical Oncology
& Radiotherapy

09th July 2024

Mr. R.A.D.G. Francis
Age 72Y/M
Colombo

Dear Sir,

QUOTATION FOR CONDUCTING GENETIC TESTING

As requested by Dr. Mahendra Perera 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)
NA3166	HRR Gene Panel (Germline) Extended	Rs. 371,400 /-

• **Terms & Conditions**

- 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- CCEYLKLX

Thanking you!



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Amila Herath
Manager Operations