

CORE DIAGNOSTICS™

Test Requisition Form

12th August 2024

Accessioning ID

TRF No.: 1080714

PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Date of Birth / Age: 54Y/F
Gender: Male Female
First Name: Mrs. Shawa Gray
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
AB1615	Inhibin A, Reproductive Marker
AH1240	Inhibin B
	5 mL Serum from 1 SST (Gel Barrier Tube)
	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: _____
Sign: _____ COREwings 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: _____

CORE DIAGNOSTICS™

Reshma Kotte Jay

Joanna all
Tues

D. Dahan. A:B



AB - 1615

Att - 1240

Dr. MAHENDRA PERERA
MBBS (Gen), MD (Gen), Dip RT
Consultant in Clinical Oncology
& Radiotherapy
Principal Investigator - Clinical Trials

Consent Form for Genomic Testing in Cancer Patients

Test Title: Genomic Testing for Risk Assessment and Targeted Therapy Planning in Cancer Patients.

Institution: Aegle Omics Private Limited, 1211 - Level 12, Parkland Building, 33, Park Road, Colombo 00200, Sri Lanka.

Contact Information: +94 (11) 743 9213 | info@aegleomics.com

Introduction:

You are hereby invited to participate in a genomic testing study. As part of this study, we will conduct a comprehensive analysis of your cancer genome utilizing your tissue material, blood, or bodily fluids. The primary objective of this testing is to gain a deeper understanding of your cancer's genomic profile and to identify potential targeted therapies that may offer enhanced efficacy in your treatment. Additionally, this genomic testing may provide insights into your risk for other cancers or health conditions.

Procedures:

1. Sample Collection:

We will collect samples of your cancer tissue during a standard medical procedure (e.g., biopsy or surgery).

Additional samples may include a blood draw and/or body fluids collection.

2. Genomic Testing:

Your samples will be sent to a laboratory overseas for genomic analysis to identify specific genetic changes related to your cancer. We take the liberty of carefully evaluating your sample to ensure its quality or quantity being right or appropriate for that particular testing, assessing its cellular content, and selecting the most appropriate test modality to sequence tissue biopsy.

3. Results and Follow-up:

Most results would take 3 - 4 weeks turn around time

Results will be discussed with you by your Primary care physician.

Recommendations for targeted therapy or further testing may be made based on your results.

4. Potential Benefits:

Personalized treatment plans based on your genomic profile.

Insight into your cancer risk and potential prevention strategies.

5. Potential Risks:

There may be a risk of emotional distress from learning about your genetic information. There is a small risk of confidentiality breaches, but strict measures are in place to protect your data.

6. Confidentiality:

Your personal information and test results will be kept confidential and stored securely. Only authorized study personnel will have access to your data.

Consent:

I have read and understood the information provided above. I have had the opportunity to ask questions, and I agree to participate in this testing procedure. I consent to the collection and analysis of my cancer tissue, blood, and/or saliva for genomic testing and for further research purposes if needed.

Further, I am aware that this test may or may not detect a treatment target for my cancer.

Participant's Name: Shawn Gray

Participant's Signature: 

Date: 8/8/2024

Guardian's Name (if applicable): _____

Guardian's Signature (if applicable): _____

Date: ~~8~~ _____

Physician's Name: Dr. Mahendra Perera

Physician's Signature: _____

Date: _____

Contact Information for Questions:

If you have any questions about this testing and treatment, please contact Aegle Omics Genomic Centre +94 (11) 743 9213.