

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: 46Y/F

Gender: Male Female

First Name: Mrs. Y.P.I Kumari

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. Sujeewa Siyambalapiiya

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
P00141	pulmoCORE Extended Panel
	Formalin fixed paraffin embedded tissue block
	Wax block 1
	PR3143

SPECIMEN DETAILS

Specimen Type	No.	Specimen Type	No.
FFPE Block	S1	Aspirate Material	S13
Whole Blood EDTA / ACD / Fluoride / Hepann / 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 Hepann 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 Barcode

Sign: _____

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: _____

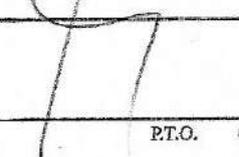
Helpline No. : +91 88828 99999

Bangalore Lab : +91 8022244777 | Delhi Lab : +91 11 46269604

Date of Birth/Age: _____ TRF No: 1080714

Test Name and Test Code: _____

MBCCC/17
 MB.
 R.H.

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			PHN												
නම වෙස්තුව Name	Mr Y. P. I. Kamani														
ලිපිනය ලිපිනය Address			වයස (වස.) වයස (වස.) Age (Years)	46	ස්ත්‍රී/පුරුෂ ස්ත්‍රී / වෙස්තුව Sex	M									
යොමු කළේ අනුප්‍රාප්තිය Referred by	රජයේ රෝගීගල රජයේ රෝගීගල Government Hosp.	<input type="checkbox"/>	පෞ.වෛ.සා. පෞ.වෛ.සා. Private Dispensary	<input type="checkbox"/>	සෞ.වෛ.නි. සෞ.වෛ.නි. MOH	<input type="checkbox"/>	තමා/මම තමා / මම Self/Other	<input type="checkbox"/>							
සායනික ඉතිහාසය සහ නිරීක්ෂණ සහ සමාජමය පරීක්ෂණය Clinical History and Examination											පරීක්ෂණ පරීක්ෂණ Investigation FBC <input type="checkbox"/> UFR <input type="checkbox"/> ESR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
ප්‍රතිකාර ප්‍රතිකාර Treatment <p style="text-align: center;"> <i>Δ CA lung Recsect</i> <i>Jan</i> <u><i>POD 141</i></u> Dr. Sujewa Siyambalapitiya MBBS, MD, MRCP-UK (S.C.H in Medical Oncology) Fellowship in Oncology (NCC, Singapore) Certified in European Society for Medical Oncology (ESMO) Consultant Clinical Oncologist <i>Plimo Core Extended Panne</i> </p>															
යොමු කිරීම අනුප්‍රාප්තිය Referred to	CNTH-Ragama				අත්සන අත්සන Signature										



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CONFIDENTIAL LABORATORY REPORT

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



ASIRI LABORATORIES

LIVE MORE

A Sollogic Group Company

Asiri Surgical Hospital PLC. No. 21, Kirimandala Mw, Colombo 05.
T. +94 11 452 4448, +94 11 452 4400 F. +94 11 452 4448 E. histolab@asiri.lk

HISTOPATHOLOGY

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

** OPD/AHH/ALS **

Page 1 of

REFERENCE No. : 01 0710 09/06/24
SAMPLE DATE & TIME : 09/06/2024 18:53
REPORT DATE & TIME : 20/06/2024 14:31 AGE : 46 Y/F
PATIENT : MRS. Y.P.I. KUMARI (130599315) / AHH2011108 / AHH8876
REFERRED BY : DR AFLAH SADIKEEN (4076/4071C)

TEST : CYTOLOGY

Clinical history:- L/LL lesion, LB6 obstructed with necrotic lesion.

Specimen :- A) Bronchial washing for cytology.
B) Bronchial brushing for cytology.

Macroscopy :- A) Received 3 ml of clear fluid. Examined 2 slides.
B) Received 2 slides.

Microscopy :- A) Smears show normal bronchial epithelial cells, superficial squamous epithelial cells, alveolar macrophages, lymphocytes and neutrophils in a background of blood stained mucus material. There are two cohesive clusters of atypical epithelial cells with moderate nuclear atypia.

B) Smears show few cohesive and dispersed atypical epithelial cells with moderate nuclear atypia. These cells show vesicular nuclei, prominent nucleoli and moderate thin cytoplasm. Background shows normal and reactive bronchial epithelial cells, inflammatory cells and blood mixed mucus material.

Diagnosis :- A) Bronchial washing, cytology :-
- Non small cell carcinoma (NOS)
B) Bronchial brushing, cytology :-
- Non small cell carcinoma (NOS)

RP

(S.C.T - 09/06/24 at 9.30 AM)

G.P.H. Ramani

DR. RAMANI PUNCHIHEWA
MBBS, D path MD, (Histopathology)
Consultant Pathologist

15th July 2024

Mrs.Y.P.I. Kumari
Age 46Y/F
Colombo

Dear Madam,

QUOTATION FOR CONDUCTING GENETIC TESTING

As requested by Dr. Sujeewa Siyambalapitiya 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)
P00141	pulmoCORE Extended Panel	Rs312,000/.

- **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- CCEYLK LX

Thanking you!



.....
Amila Herath
Manager Operations

Patient Name	Mrs.Y.P.I. Kumari
Age	46 Y/F
Referral	Dr. Sujeewa Siyambalapitiya
Organisation	Core Diagnostics
Invoice No	AO0035

Invoice

Date: 15th July 2024

#	Test Description	Amount	
1	pulmoCORE Extended Panel	LKR	312,000.00
	Total		312,000.00

Mode of Payment	Cash	Card	Bank Transfer
		LKR	LKR 312,000.00

Received Total Amount	312,000.00
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[Handwritten Signature]

Issuing Officer's signature