

Sample Receipt Details:

POD : _____ Temp : _____
 Date & Time : _____ Sample Type : _____
 CS Name & Sign: _____ Logistics Name & Sign : _____
 Prenatal Sample Yes No Bill type MOU Retail Research

TEST REQUISITION FORM

Disease Segment* _____

Each sample must be accompanied by this completed requisition. * Fields are mandatory

Test Details

Test Name: * Endometrial Cancer Basic NGS Panel **Test Code:** * MGM3239 , MGM1789
PD-L1 Dako 22C3 IHC Pharm Dx

Sample type:

<input type="checkbox"/> Blood (in EDTA tube)	<input type="checkbox"/> Blood (in streck tube)	<input type="checkbox"/> DNA, Specify Source: _____	<input type="checkbox"/> Buccal swab
<input type="checkbox"/> Amniotic Fluid	<input type="checkbox"/> CVS	<input type="checkbox"/> Cultured CV	<input type="checkbox"/> Cultured amniocytes
<input type="checkbox"/> Fetal Blood (PUBS)	<input type="checkbox"/> Maternal blood for MCC (please send for prenatal studies)	<input type="checkbox"/> Products of Conception (POC), specify tissue: _____	<input checked="" type="checkbox"/> FFPE tissue Block (Block no. IL8568)
<input type="checkbox"/> Fresh Frozen Tissue	<input type="checkbox"/> Saliva	<input type="checkbox"/> Other sample type (specify site) _____	<input type="checkbox"/> DBS/FTA

Patient had a blood transfusion Yes No Date of last transfusion ____ / ____ / ____ (minimum 3 days of wait time is required for genetic testing)
 Has he/she undergone allogenic bone marrow transplant: Yes No.

Patient Details

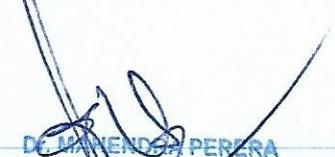
Name: * Mrs. C. Nilmini Thenuwara (In Capital Letters) D.O.B. DD MM YY Age: * 63Y/F Gender: * M / F
Address: _____
Phone: _____ **E-mail I.D:** _____

Clinician Details

Clinician's Name: Prof. Jayantha Balawardana **Hospital Affiliation:** _____
Address: _____ **Phone :** _____
Email id : _____

Date of sample collection* 27 06 2024

I understand that the current analysis is limited to variants which co-relate with disease phenotype/symptoms/terms as mentioned in the clinical details provided by me. Incidental findings which may or may not be actionable are not routinely reported. They can however be provided on request after informed consent from the patient/guardian. As disease phenotype may evolve over time, the appearance of new symptoms/signs may alter test results or their significance: MedGenome laboratories cannot be held responsible for this. A re-analysis or a re-test may be required due to the former; this will be performed (if deemed necessary) at an additional cost. I am authorised to order the above tests as I am the treating physician/consulting physician in this case. I confirm that the patient/guardian (in case of minors) has been provided complete information regarding the test, including its limitations in a language of their understanding.

Medical Professional Signature*  **Date:** _____ **Place:** _____
Clinical notes/diagnosis
 Dr. Jayantha Balawardana
 Consultant in Clinical Oncology & Radiotherapy
 Principal Investigator - Clinical Trials

Disease affection status Yes NO **Parental consanguinity present** Yes NO **Age of manifestation:** _____
Affected Siblings Yes NO **Details:** _____

GOVERNING LAW, JURISDICTION AND DISPUTE RESOLUTION

These Terms and Conditions and this Test Requisition Form shall be governed by and construed in accordance with Indian law and the courts in Bangalore shall have exclusive injunctive jurisdiction. In the event of any dispute, controversy or claim whatsoever arising from these Terms and Conditions and/or this Test Requisition Form, the parties shall undertake to make every effort to reach an amicable settlement within fifteen (15) days upon reference of the dispute by any party through discussions among the concerned representatives of parties, failing which the dispute, controversy or claim shall be settled by Arbitration by a Sole Arbitrator appointed by the 'President-Arbitration Centre-Karnataka', Bangalore as per Indian Arbitration and Conciliation Act, 1996 as amended from time to time. The venue of arbitration shall be Bangalore and it shall be conducted in English language. The award passed by the Sole Arbitrator shall be final and binding upon the parties.

NOTICE

All notices, statements or other communication required or permitted to be given or made shall be in writing and in English language. Such notices will deliver by hand or sent by prepaid post with recorded delivery, or facsimile transmission addressed to the intended recipient at the address mentioned in this Test Requisition Form.

INDEPENDENT PARTIES

All parties effected hereunder are independent entities and neither of the parties are an agent, employee or joint venture of the other and they shall not represent themselves as such to any third parties.

REFUND

Refund of fees for any reason has to be claimed by the Patient or the guardians of the Patients within 90 days from the date of delivery of report.

Patient/Guardian Authorization

By my signature below I attest to the following:

I have read and I understand the information provided on this form.

Patient Consent (sign here or on the consent document)

I have read the Informed Consent document and I give permission to MedGenome to perform genetic testing as described. I also give permission for my specimen / genetic data to be used in (de-identified) studies at MedGenome to improve genetic testing for other patients.

By agreeing to this informed consent below, I am confirming that I understand the benefits, risks and limitations associated with genetic testing. Furthermore, I am affirming that I recognize the seriousness of conditions for which {I am/my child} being tested, and that disease descriptions, prognoses, and treatment options have been made available to me by {my/my child's} health care provider. Finally, if I have the legal authorization to provide this informed consent on behalf of another person, I am attesting that the sample provided belongs to that person.

Patient/Guardian Name Mr. Thenuwara

First Name Middle Name Last Name Date of Birth: mm/dd/yyyy

Patient/Guardian Signature* Date: Place:

Father Name Mother Name

Signature* Date and time Signature* Date and time

Relationship with the proband

Note :

Signature of both parents is requested for prenatal testing.

For trio testing, each parent should provide separate informed consent for the sequencing of his or her sample.





1st Joint Commission International (JCI)
Accredited Hospital in Sri Lanka



ISO 15189
ML 010

HISTOPATHOLOGY REPORT

Patient Name: **MRS C NILMINI THENUWARA**

Location : **MAIN LAB-IN PATIENT**

Age / Gender : **63 Y / F**

Invoice Date : **27/06/2024** Time: **1:49PM**

Specimen No: **AAIN4289160-270624** UHID: **REG240136883**

Specimen Type : **TISSUE**

Testing Unit : **HISTOPATHOLOGY & CYTOLOGY**

Specimen Collect Date : **2024/06/27** Time: **1:30PM**

Patient Code : **BHT514169**

Referred By : **R.COLONNE**

Test Method :

Ward : **WARD 9A (DMSH) /** RoomNo: **9A-903**

HISTOPATHOLOGY REPORT

SPECIMEN : Endometrial biopsy.

MACROSCOPY : Profuse haemorrhagic curettings.

MICROSCOPY : Sections show a tumour comprising crowded focally confluent tubular glands lined by columnar epithelium with crowded pleomorphic nuclei with scattered mitoses and eosinophilic cytoplasm. Focal tumour necrosis and squamous metaplasia are also seen.

CONCLUSION : Appearances are consistent with a well differentiated endometrioid adenocarcinoma of uterus.

IL 8568

** Blocks and slides of this specimen will be retained as follows -
Slides - Five years / Blocks - Ten years from the date of issue
of this report. Specimen will be kept for one month only.

Dr. A. Illeperuma
D. Path. - MD (histopath) *Abel*
Consultant histopathologist

Dr. A. Illeperuma

D Path MD (Histopath) Consultant Pathologist
DURDANS LAB - COLOMBO 3

Printed on: 01/07/2024 1:20:44PM

Prof L R Amarasekara
MBBS Ph D (Lond)
Consultant Pathologist

Prof Janaki Hewavisenthi
MBBS D Path
MD (Histopathology)
Consultant Pathologist
University of Kelaniya

Prof Dilani Lokuhetty
MBBS D Path MD
Consultant Pathologist

Dr Janaki Fernando
MBBS Dip Path
M D Histo Path
Consultant Pathologist
North Col Gen Hospital

Dr A Illeperuma
D Path MD (Histopath)
Consultant Histopathologist

Dr Renuka Goonesinghe
MBBS D Path MD(Histopath)
Consultant Histopathologist

Dr Bandula Perera
MBBS D Path MD(Anatomic)
Consultant Pathologist

Dr Modini Jayawickrama
MBBS D Path M D Path (Histo)
Consultant Pathologist

Dr Karuna Dissanayake
MBBS D Path
MD (Histopathology)
Consultant Histopathologist

Dr Shanika Fernandopulle
MBBS (Colombo) D Path
MD (Histopathology)
Consultant Pathologist

Dr Sriyani Nanayakkara
MBBS D Path MD (Histopath)
Consultant Pathologist

Dr Bhadraraj Ranasinghe
MBBS, D. Path, MD (Histopathology)
SLMC Reg. No. - 13583
Consultant Histopathologist

Dr Nelum Gamage
MBBS D Path
MD (Histopathology)
Consultant Histopathologist

Dr Ineesha Jayasinghe
MBBS D Path
MD (Histopathology)
Consultant Histopathologist

21st August 2024

Mrs. C. Nilmini Thenuwara
Age 63 Y/F
Kandy

Dear Madam,

QUOTATION FOR CONDUCTING GENETIC TESTING

As requested by Prof. Jayantha Balawardana Oncologist, we are pleased to offer you the following services for Diagnostic purpose through MedGenime Labs Limited, Bangalore India.

Financial Offer

Assess Cord	Test Name	Cost for the Toal Package (LKR)
MGM3239	Endometrial Cancer Basic NGS Panel	Rs. 453,225 /-
MGM1789	PD-L1 Dako 22C3 IHC Pharm Dx	

- **Terms & Conditions**
- Diagnose results, reports will be given after 27 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

Thank you!



Amila Herath
Manager Operations