

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

[Combo] Lung combo panel

Test Name:* **PD-L1 Dako 22C3 IHC Pharm Dx** Test Code:* **MGM573 , MGM1789**

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.)
<input type="checkbox"/> Fresh Frozen Tissue	<input type="checkbox"/> Saliva	<input type="checkbox"/> Other sample type (specify site) _____	<input type="checkbox"/> DBS/FTA

RD816/H/24
RD790/H/24

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

2 Blocks

Patient Details

Name:* **Mr. A.S. Jayalath Silva** D.O.B. **DD MM YY** Age:* **44 Y/M** Gender:* **M/M**
 (In Capital Letters)
 Address: _____
 Phone: _____ E-mail I.D: _____

Clinician Details

Clinician's Name: **Dr. Mahendra Perera** Hospital Affiliation: _____
 Address: _____ Phone : _____
 _____ Email id : _____

Date of sample collection* **09D 07M 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.

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

Medical Professional Signature* _____ Date: **23/9/2024** Place: **Colombo**

Clinical notes/diagnosis: _____

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.

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.

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.

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. A.S. Jayalath Silva

First Name	Middle Name	Last Name

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.



ආ. සී. ඩී. අංකය }
B. H. T. No. }

දිනය
Date

දිනපතා තත්වය / DAILY STATE

16/8/23

Dr. Mahendru Perera

Consultant Oncologist ✓

Dear Sir

Re. M.S. Jayalath De Silva
Cancer

Please be advised to see and

advise on metastasis testing for

The patient

Yours faithfully
[Signature]

[Signature]

Dr. T. SKANDARAJAR
MBBS, MD (Clinical Oncologist)
Consultant Oncologist
Cancer Hospital Maharagama
SLMC Reg. No: 12920

MM - 573 (Lip Cancer)

MM - 1789

DEPARTMENT OF ANATOMICAL PATHOLOGY
NATIONAL HOSPITAL FOR RESPIRATORY DISEASES (TEACHING)
WELISARA – SRI LANKA

TEL: 0112956702 Ext: 121

HISTOLOGY REPORT

Name :- Mr. A. W. S. Jayalath Silva.
Age :- 44yrs.
Sex :- Male.
Requesting Dr:- Dr. Wathsala Gunasinghe.
Date Received: - 09.07.2024

Ref. No: - RD790H/24.
Hospital: - NHRD – Welisara.
Ward: - 01
BHT/clinic No: - 6889/24
Date Issued: - 12.07.2024.

Clinical history:- Left side effusion.

CXR – Right side effusion.

CT – Left lung lower lobe bronchial carcinoma.

FOB – Aspiration cytology – Negative for malignancy.

? Lung carcinoma.

Specimen:- CT guided tru cut biopsy from lesion at left lung lower lobe for histology.

Macroscopy:- Received a fragmented linear core of tissue; The largest fragment measuring – 06mm in length and the smallest fragmet measuring – 02 mm in length. (All paased in.01 block).

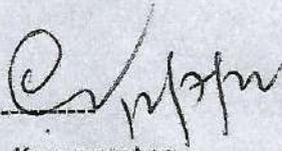
Microscopy:- :- Sections reveal a fragmented core of tissue. More than 90% of the core show necrosed/non viable tissue.The rest shows few malignant glands of a moderately differentiated adenocarcinoma.

Conclusion:- CT guided tru cut biopsy from lesion at left lung lower lobe:-

-Moderately differentiated adenocarcinoma .

? Primary / ? Secondary

- A supplementary report will follow after immunohistochemistry.


 DR. Vasana Karunaratne
 (Consultant Histopathologist).

Dr. Vasana Karunaratne
 MBBS, Dip. in Pathology,
 MD Histopathology
 Consultant Histopathologist
 National Hospital for
 Respiratory Diseases
 Welisara

DEPARTMENT OF ANATOMICAL PATHOLOGY
NATIONAL HOSPITAL FOR RESPIRATORY DISEASES (TEACHING)
WELISARA - SRI LANKA

TEL: 0112956702 Ext: 121

HISTOLOGY REPORT

Name :- Mr. A. S. Jayalath Silva.

Age :- 44yrs.

Sex :- Male.

Requesting Dr: - Dr. Dhammika Rasnayake.

Date Received: - 13.07.2024.

Ref. No: - RD816H/24.

Hospital:- NHRD – Welisara.

Ward: - 04.

BHT/clinic No: - 6889/24.

Date Issued: - 30.07.2024.

Clinical history:- Left side effusion.

Left side VATS exploration done. Blood stained pleural effusion.

Multiple metastasis on pleura diaphragmatic ad on lung disease biopsy done.

Specimen:- Left side parietal pleural biopsy for histology.

Macroscopy:- Received three fragments of brownish tissue:the largest measuring – 10mm x 10mm x 10 mm and the smallest measuring – 06mm x 04 mmx 04 mm. (All passed in 01 block).

Microscopy:- Sections reveal multiple fibro connective tissue fragments containing a moderately differentiated adenocarcinoma. The tumor show papillary structures with thick fibro connective cores.

Immunohistochemistry:-

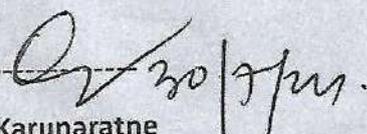
CK 7 – Tumor cells show strong cytoplasmic positivity.

TTF 1 – Tumor cells shows strong nuclear positivity

CK 20- Tumor cells are negative.

Diagnosis:- Left side parietal pleural biopsy:-

- Findings favor a primary lung adenocarcinoma with papillary morphology.
- Suggest clinical /radiological correlation.


DR. Vasana Karunaratne
Consultant Histopathologist

Dr. Vasana Karunaratne
MBBS, Dip. in Pathology,
MD Histopathology
Consultant Histopathologist
National Hospital for
Respiratory Diseases
Welisara

මුදා හැරීමේදී සිදුවන කළ මාංශපි (මාංශපි / මාංශපි / සිරුරේදී / දිය යුතු අවස්ථාව / කාල පරිච්ඡේදය)
 කොමියුනිකේෂන් පිළිබඳව, පැහැදිලි කිරීමක් (සෞඛ්‍ය සේවකයන්ගේ අවබෝධය වැඩි කිරීම සඳහා) සඳහා භාවිත කරන්න.

IV eefuramue 750mg R/H - 16 days

** කරුණාකර ඔබට නියම කරන ලද මාංශපි වෛද්‍ය උපදෙස් පරිදි පාවිච්චි කරන්න.
 தயவு செய்து, உமக்கு கொடுக்கப்பட்ட மூலதங்களை வைத்திய ஆலோசனைக்கு அமைவாக உட்கொள்ளவும்.
 Please use prescribed medications as advised by the Physician.

Discharge Plan: (Inclusive of Management plan, Advices, Diet, Life Style Behaviour)
 මුදාහැරීමේදී අනුමත කළ යුතු සැලැස්ම (ප්‍රතිකර්ම සැලැස්ම වෛද්‍ය උපදෙස්/ආහාර/ජීවන රටාව සහ සැලැස්ම අන්තර්ගතය)
 කොමියුනිකේෂන් පිළිබඳව, පැහැදිලි කිරීමක් (සෞඛ්‍ය සේවකයන්ගේ අවබෝධය වැඩි කිරීම සඳහා) සඳහා භාවිත කරන්න.

R/v at clinic in 1/2 08/08/24
 - CKxay PA
 - Trace Hecology report

Follow up Details / පසු වෛද්‍ය විස්තර / தொடர் கண்காணிப்பு விவரங்கள்

Date දිනය Date	Day දවස Day	Time වේලාව Time	Type of Clinic විශේෂඥ කාංශාය Type of Clinic	Consultant's Name විශේෂඥ වෛද්‍යවරයාගේ නම கonsultant's Name	Room No. කමර අංකය Room No.

Instructions in Sinhala or Tamil (Optional) (Eg. - Disease Condition, Medication, Referrals)
 උපදෙස් ලබාදීම සිංහලෙන් හෝ දෙමළෙන් (අවශ්‍ය වූ විටසඳී)
 (විශේෂඥ, ඖෂධ, යොමු කිරීම් සඳහා)
 MO ODD / LH
 Dear Dr
 Please remove this patient's sutures
 On 07/07/24

Referral Note / යොමු කිරීමේ සටහන / යොමු කිරීමේ සටහන
 Thanky
 SB - Dr. Anshu. 8/07/2024
 tube site - 002mg +

Medico-Legal
 අධිකරණ වෛද්‍ය සටහන
 MLEF No. Date
 අධිකරණ වෛද්‍ය අංකය, දිනය
 VS Indured.
 Name of JMO
 අධිකරණ වෛද්‍ය නිලධාරියාගේ නම
 get down on 08/08/24
 & Histology Report + CKx

** ඔබ සිහියට වෛද්‍යවරයාගේ ඉඩුවෙන්මෙන් නම් මෙම රෝග නිවේදන පත් ඉදිරිපත් කරන්න.
 (විශේෂඥ වෛද්‍යවරයාගේ ඉඩුවෙන්මෙන් නම් මෙම රෝග නිවේදන පත් ඉදිරිපත් කරන්න.)
 Please produce this Diagnosis Card at your next consultaion.



රෝග නිවේදන පත
 நோய் நிர்ணய அட்டை
Diagnosis Card

සමස්ත 383 ට
 සංකීර්ණ 383 ට

Hospital
 රෝහල
 ස්ථාන නම
 NHRO

Contact No. දුරකථන අංකය தொலைபேசி இல.	NIC No. ජාතික හැඳුනුම්පත් අංකය த.அ.அ.இ.எ.	Blood Group ලේ රසය இரத்த வகை.	Allergy (Drug/Food/Other) අධිකරණ (මාංශපි/ආහාර/වෙනත්) ஒயிலா மருந்து / உணவு / வேறு (எனது)
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Patient's Name
 රෝගියාගේ නම
 நோயாளியின் பெயர்
 Ms - A. Suranga Jayakala Silva.

BHT No අදාළ අංකය தலைமட்டில் சி.எ.எ. இல.	Ward/Unit වාර්ඩ්/ඒකකය வார்டு/யூனிட்	Sex Male/Female ස්ත්‍රී පුරුෂ සාමාන්‍ය/ආහාර பால. ஆண் / பெண்	Age වයස வயது
6889/24	04	male	44y

Date of Admission අදාළ කල දිනය அனுமதிக்கப்பட்ட திகதி	Date of Discharge මුදාහැර දිනය வெளியேறிய திகதி
24 / 08 / 24	30 / 07 / 24

Principal Diagnosis
 ප්‍රධාන රෝග විනිශ්චය
 முதன்மை நோய் நிர்ணயம்
 LT/s VATS Exploration + Biopsy
 + TALE Pleurodesis. done on 09/07/24

Co-morbidities
 Surgeries
 Procedures
 වෙනත් රෝග සහ සමස්ථයන්
 සලකුණු
 අදාළ වෛද්‍ය ක්‍රියා
 இலகை நோய் / அறுவைகள்
 சத்திர சிகிச்சைகள்
 செயல்படுத்தப்பட்டன

I° - Lt/s massive pl. effusion

Mode of Admission රෝහලට අදාළ කල අවස්ථාව காணத்திர/மருமுகம் அனுமதிக்கப்பட்ட முறை	Self පමා විසින් சுயம்	Requested / Referred ඉල්ලීම මත / යොමු කිරීමකින් கேள்வியுடைய / යොමු කිරීමකින් By Whom සමුදාය විසින් யாருடன்	Transferred in මාරුකර එවීම பெயர்க்கப்பட்ட இடமாற்றம்
	<input type="checkbox"/>	Dr. Walsala Hospital Dr. Gunasinghe (cep)	<input checked="" type="checkbox"/>

Mode of Discharge මුදාහැර අවස්ථාව வெளியேறிய முறை	Routine සාමාන්‍ය විවේචන சාමාන්‍යமாக	Transferred Out මාරුකර යැවීම வெளியே அனுப்பப்பட்ட இடமாற்றம்	Self Discharge වෛද්‍ය නිලධාරියාගේ සහ சுயமாக வெளியேற
	<input type="checkbox"/>	Hospital රෝහල கොමියුනිකේෂන්	<input type="checkbox"/>

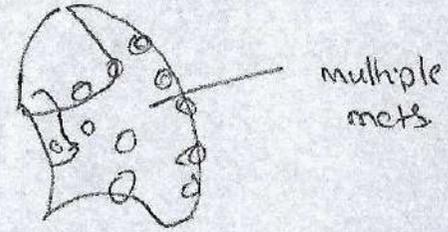
Disease Notification රෝගය දැනුම්දීම நோய் அறிவிப்பு	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Consultant's Name and Stamp විශේෂඥ වෛද්‍යවරයාගේ නම සහ නිල මුද්‍රාව கonsultant's Name and Stamp	Dr. Dammika Ranayaka
Medical Certificate Issued වෛද්‍ය සහතිකය නිකුත් කිරීම மருத்துவ சான்றிதழ் வழங்கப்பட்டது	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	H/O/MO Name විශේෂඥ වෛද්‍ය නිලධාරියාගේ නම கonsultant's Name	Dr. D. D. Saman Edirisinghe
Insurance Form Filled රජයේ සේවයේ සහභාගී காணத்திர/மருமுகம்	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Signature / අත්සන கையொப்பம்	(Signature)

Presenting Complaint, History, Examination Findings, Treatment / Surgical Procedures

രോഗ ചരിത്രം, രോഗ ഊന്നലുകൾ, രോഗിയിലെ പരിചരണം, പ്രതികരണം, പ്രതികരണങ്ങൾ
 തർജ്ജമ ചെയ്ത പ്രതികരണങ്ങൾ, ചികിത്സ, പരിശോധനകൾ, പ്രതികരണങ്ങൾ / ചികിത്സ / ചികിത്സകൾ

Lt/S VATS Exploration + Biopsy +
 TALC pleurodesis done L on 09/07/24
 by Dr. Sameera (sr) / Dr. Laxantha (mo)

Single post VATS
 Blood stained effusion drained



Multiple mets found & collapsed lung

Biopsy done.
 TALC pleurodesis done
 Haemostasis achieved.
 28 Fr chest tube inserted
 Routine closure done. Specimen sent for histology

post op poor lung expansion
 Daily Drainage ↑
 01 Bottle TALC pleurodesis done in the ward.

Investigations

പരിചരണം വാർത്ത
 പരിശോധനകൾ
 Hb - 14.8 g/dl
 WBC - $10 \times 10^3 / \text{mm}^3$
 Plate count - $265 \times 10^3 / \text{m}$
 ALT - 33 U/L
 AST - 31 U/L
 SGPT - 3.9
 Na - 141
 S-creatinine - 0.9 mg/dl
 PT / INR - 1.01

Sputum AFBx - negative
 HIV - } negative
 HepB sAg }
 2D Echo - NL

Special Investigations: (Eg.- Histology Report, CT Scan)

വിശദ പരിചരണം വാർത്ത (രോഗി - രോഗി വിവരങ്ങൾ / രോഗി വിവരങ്ങൾ)
 വിശദ പരിശോധനകൾ (ഉദാഹരണം : തിരുവില്വാമല അന്വേഷണം, CT സ്കാൻ)
 CT guided biopsy from Lung lesion
 moderately differentiated adenocarcinoma.
 ? IY / 2019
 The will follow
 ECG chest 28/06/24. Bronchial CA T1 No M1

Patient's Condition at the Time of Discharge

മുഖ്യമായും രോഗിയുടെ രോഗിയുടെ അവസ്ഥ
 രോഗിയുടെ നിലയിൽ രോഗിയുടെ നിലയിൽ
 Ict removed on 30/07/24
 CXray PA -

DEPARTMENT OF RADIOLOGY
NATIONAL HOSPITAL FOR RESPIRATORY DISEASES
WELISARA

Mr.Suranga Silva, 44yrs
WD:01
28/06/2024

CECT CHEST - 3001/24

Primary tumor:
21x28mm sized low density soft tissue nodule in collapsed L/LL.

LN s:
None.

Metastases:
Lobular pleural thickening and fluid along the upper half of L/hemi thorax. Basal L/lung show some small nodular pleural thickening.

Other findings:
No lung parenchymal lesion on right side or aerated left lung.
Normal sized heart with no pericardial effusion.
Draining chest tube in situ in left hemi thorax.
No liver lesion or supra renal masses.
↳ sinister bone lesion.

Conclusion:
Pulmonary CA - T1 No M1a.

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Dr.S.H. Palihawadana

Dr.(Mrs.) SUMUDU H. PALIHAWADANA
MBBS, MD, FRCR, FRANZCR
Consultant Radiologist
National Hospital for Respiratory Diseases
Weligama