

# TEST REQUISITION FORM

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

## Test Details

### Gastrointestinal Stromal Tumor (GIST) Panel (SNVs, InDels and Fusions)

Test Name: \_\_\_\_\_ Test Code: **MGM333**

Sample type:  Blood (in EDTA tube)  Blood (in streck tube)  DNA, Specify Source: \_\_\_\_\_  Buccal swab

Amniotic Fluid  CVS  Cultured CV  Cultured amniocytes

Fetal Blood (PUBS)  Maternal blood for MCC (please send for prenatal studies)  Products of Conception (POC), specify tissue: \_\_\_\_\_  FFPE tissue Block (Block no. ....)

Fresh Frozen Tissue  Saliva  Other sample type (specify site) \_\_\_\_\_  DBS/FTA **01-4108(04/08) 3 Wax Block**  
**SK9666A**  
**SK9666B**  
**SK9666C**

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 allogeneic bone marrow transplant:  Yes  No.

## Patient Details

Name: **MRS. K.S. WEERASINGHE** D.O.B. **DD MM YY** Age: **62Y/F** Gender: **M / F**

(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\* **9/9/2024** **YY**

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. ModGenome 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 authorized 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, MCh, Dip RT**  
**Consultant in Oncology**  
**& Radiotherapy**

Medical Professional Signature\* \_\_\_\_\_ Date: \_\_\_\_\_ Place: \_\_\_\_\_

Clinical notes/diagnosis: \_\_\_\_\_

Disease affection status  Yes  NO Parental consanguinity present  Yes  NO Age of manifestation: \_\_\_\_\_

Affected Siblings  Yes  NO Details: \_\_\_\_\_

2<sup>nd</sup> September 2024

Mrs. K. S. Weerasinghe  
Age 62Y/F

Colombo

Dear Madam,

**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 MedGenime Labs Limited, Bangalore India.

**Financial Offer**

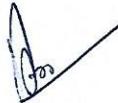
Assess Cord	Test Name	Cost for the Toal Package (LKR)
MGM333	Gastrointestinal Stromal Tumor (GIST) Panel (SNVs, InDels and Fusions)	Rs.310,350 /-

- **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

Thank you!



.....  
Mr. Amila Hearth  
Manager Operations