

Sample Receipt Details:

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

TEST REQUISITION FORM

Disease Segment* _____

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

Test Details

Tumor BRCA1 & BRCA2 Gene Analysis

Test Name:* _____ Test Code:* **MGM537**

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

2024-2903 8
2024-2903 10

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 Wax Blocks**

Patient Details

Name:* **Mr. T. Nandasiri** (In Capital Letters) D.O.B. **DD MM YY** Age:* **68Y/M** Gender:* **M / F**

Address: _____

Phone: _____ E-mail I.D: _____

Clinician Details

Clinician's Name:* **Dr Roshan Gunaratne** Hospital Affiliation: _____

Address: _____ Phone : _____

_____ Email id : _____

Date of sample collection* **27** | **10** | **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 tumors) has been provided complete information regarding the test, including its limitations in a language of their understanding.

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

Medical Professional Signature* _____ Date: _____ Place: _____

Clinical notes/diagnosis: _____

Disease affection status Parental consanguinity present Age of manifestation: _____

Affected Siblings 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. T. Nandasiri

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.

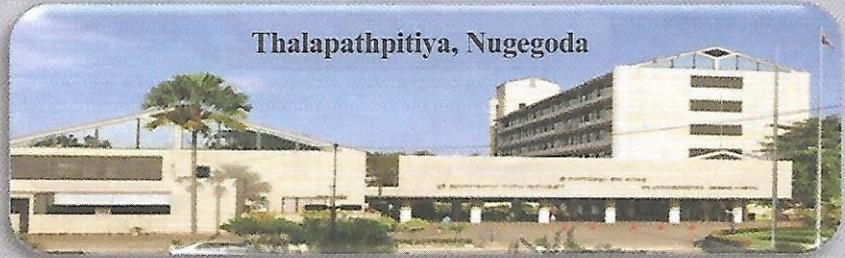
Name : M T. Nandana Date : 2019/10/18
Age : 68

Ca prostate
(no family history)
G + P = 5 + 4 = 9
PSA 8.9

Wax block
BRCA I / II

Dr. Roshan Gunaratne
MBBS, MD
Consultant Clinical Oncologist
SLMC Reg. No. 16753

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Consultant Clinical Oncologist
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Thalapathpitiya, Nugegoda

An excellent health care with state responsibility

Tel: 011-2778610 Fax: 011-2778622, Ext: Histology (3028), Bio Chemistry (3033), Haematology (3060), Microbiology (3036) E-mail: laboratory@sjghsrilanka.lk, Web: sjgh.health.gov.lk

HISTOPATHOLOGY REPORT

NAME : Mr. T. Nandasiri AGE : 68 Yrs
CASE NO : 2409464 SEX : M
REF. BY : WARD : 14

LAB REF. NO/HI/ 2903/2024

Specimen - Prostate core biopsies (TRUS).

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ඔබගේ වෛද්‍ය වරයාට/වරියට පෙන්වන්න
**PLEASE SHOW THIS REPORT
IMMEDIATELY TO YOUR DOCTOR**

Macroscopy

- Received -
- 01. One core of tissue measuring 0.6 cm in length and one minute fragment.
 - 02. One core of tissue measuring 1 cm in length
 - 03. One core of tissue measuring 0.6 cm in length
 - 04. One core of tissue measuring 1 cm in length
 - 05. One core of tissue measuring 0.7 cm in length
 - 06. One core of tissue measuring 0.7 cm in length
 - 07. One core of tissue measuring 0.5 cm in length and one minute fragment.
 - 08. One core of tissue measuring 0.5 cm in length and one minute fragment.
 - 09. Two cores of tissue measuring 0.5 cm in length and one minute fragment.
 - 10. One core of tissue measuring 1 cm in length
 - 11. One core of tissue measuring 0.8 cm in length
 - 12. One core of tissue measuring 1 cm in length

Microscopy

Sections from TRUS biopsies of prostate confirm the presence of a prostatic adenocarcinoma.
The tumour is composed of single separate dysplastic cells and fused glands infiltrating the stroma.

Cont. page 2

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Date

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Medical Laboratory Technologist

.....
Consultant

Dr. Prabhath Ambawatta
Consultant Pathologist
MBBS, D PATH, MD, (Pathology) Col

Dr. (Mrs.) Sonali Rodrigo
Consultant Pathologist
MBBS, D PATH, MD, (Pathology) Col

Dr. Prabhath Ambawatta
MBBS, D PATH, MD, (Pathology) Col
Dr. (Mrs.) Chitranga Kariyawasan
Consultant Haematologist
Sri Jayewardenepura General Hospital
MBBS, D PATH, MD, (Haematology)

Dr. (Mrs.) Kushlani Jayatilleke
Consultant Microbiologist
MBBS(Col), Dip. Medical Microbiology,
MD Microbiology

Dr. (Mrs.) Neranjana Vithanage
Consultant Chemical Pathologist
MBBS, D PATH, MD, Chemical Pathology



Conclusion

Prostate core biopsies (TRUS) –
(01). **Prostatic adenocarcinoma.**
(02). Gleason grade – 5 + 4
(03). Percentage of core involvement

<u>Core No.</u>	<u>Gleason score</u>	<u>Percentage of involvement</u>
01	5 + 4	40%
02	5 + 4	30%
03	5 + 4	20%
04	5 + 4	10%
05	5 + 4	10%
06	5 + 4	20%
07	5 + 4	40%
08	5 + 4	50%
09	5 + 4	50%
10	5 + 4	70%
11	5 + 4	50%
12	5 + 4	50%

30.09.2024


Dr. Prabhath Ambawatta
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Consultant Pathologist
Sri Jayawardenepura General Hospital