

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

Endometrial Cancer gene panel (SNVs, InDels & Fusions)

Test Name:* _____ Test Code:* **MGM2581**

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: _____	* 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

4893AXX1
4893AX11
4893AX1X
4893AXX

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. **4 wax Blocks**

Patient Details

Name:* **Mrs. M.R.D.M.R. Gunarathne** D.O.B. **DD MM YY** Age:* **63Y/F** Gender:* **M / F**
(In Capital Letters)

Address: _____
 Phone: _____ E-mail I.D: _____

Clinician Details

Clinician's Name: **Dr. T. Skandarajha** Hospital Affiliation: **Aegle Omics Pvt Ltd**
 Address: _____ Phone : _____
 _____ Email id : _____
 Date of sample collection* **24/9/2024 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: 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. MAHEERA PERERA
 MBBS (Gen), Dip RT
 Consultant in Clinical 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: _____

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 Mrs. M.R.D.M.R. Gunarathne
 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 M. Columba

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.

ද. හි. ම. අංකය }
B. H. T. No. }

දිනය
Date

දිනපතා තත්වය / DAILY STATE

1/11/24

Dr. Mohendra Perera

Senior Consultant Oncologist

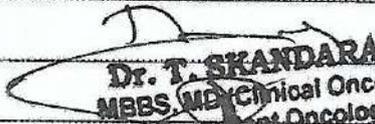
Dear Sir

Re: MRDMR Cancer Care

Please be let us to
engage molecular studies by

the robot with return

Kind regards,


Dr. T. SKANDARAJAH
MBBS, MD (Clinical Oncologist)
Consultant Oncologist
Cancer Hospital Mahar. Jn.
SLMC Reg. No: 12920

MRS. M. R. GUNARATHNE

Fecal loading in the colon.

No bony metastasis.

The liver is normal in size and smooth margins. There are no focal lesions to suggest hepatic metastasis. Intra-hepatic bile ducts and CBD are not dilated.

The gall bladder is normal.

The spleen is not enlarged. There are no focal lesions to suggest splenic metastasis.

The pancreas is normal. There is no evidence of tumours, calcification or duct dilation.

B/L Supra-renal glands and both kidneys appear normal. There is no hydronephrosis.

There is no ascites.

Bladder distended and appears normal.

Bowels and rectum are normal.

COMMENT :-

- **Known CA endometrium.**
- **No evidence of local infiltration , lymphadenopathy or distant metastasis.**
- **Multi nodular goiter. Suggest US scan.**

**Reported By : Dr. W. Meegoda
Consultant Radiologist**

18th of September 2024