

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

**Microsatellite Instability (MSI) by fragment analysis
Tumor BRCA1 & BRCA2 Gene Analysis**

Test Name: _____ **Test Code:** **MGM2732 , 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

2 x 10ml of Peripheral blood in Streck tube
 PC248D
 PC248E
 PC248C

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 **3 Wax Block**

Patient Details

Name: * Mrs. Rehana Rahman (In Capital Letters) **D.O.B.** DD MM YY **Age:** * 71Y/F **Gender:** * M / F
Address: _____
Phone: _____ **E-mail I.D:** _____

Clinician Details

Clinician's Name: * Dr. Mahendra Perera **Hospital Affiliation:** Aegle Omics Pvt Ltd
Address: _____ **Phone :** _____
 _____ **Email id :** _____
Date of sample collection* 2/1/2025 (Wax Block) Blood 4/2/2025

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), Dip. Oncol, 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.

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)

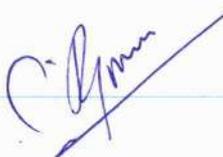
I have read the Informed Consent document and I give permission to MedGenome to perform genetic testing as described. I also give permission for my specimen / genetic data to be used in (de-identified) studies at MedGenome to improve genetic testing for other patients.

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 Mrs. Rehana Rahman
 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.

Dr. S. S. S.

Dr. S. S. S.

Dr. S. S. S.

Dr. S. S. S.

① ~~Dr. S. S. S.~~

Dr. S. S. S.

Dr. S. S. S.





CONFIDENTIAL LABORATORY REPORT

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HISTOPATHOLOGY

Block and slides of this specimen/s will be retained ONLY for six months after the date of this report. Specimen will be kept for one week

** OPD/AHH/ASH **

Page 1 of 2

UHID : 120459082
 REFERENCE No. : 01.0328.02/01/25
 SAMPLE DATE & TIME : 02/01/2025 11:53
 REPORT DATE & TIME : 15/01/2025 16:58
 PATIENT : MRS. BEBANA RAHMAN
 REFERRED BY : DR. (MRS) LAKMALIE PARANAHEWA

AGE : 71 Y/F 17/08/1953

AHH2099932 / ASH5253

TEST : HISTOPATHOLOGY REPORT

Clinical features :- Mass of malignant nature in the left breast.

Specimen :- Trucut biopsy of mass n the left breast.

Macroscopy :- Five cores of tissue measuring 17, 8, 18, 13 and 12 mm in length.

Microscopy :- Sections confirm the presence of an invasive carcinoma composed of nests of pleomorphic cells showing enlarged, irregular, hyperchromatic nuclei. Intracytoplasmic vacuoles are present. Tubular structures account for less than 10% of the tumour volume. There is focal tumour necrosis. The mitotic count is 8/2mm² (H.P.F) Cytoarchitectural features place the tumour in Nottingham grade 3 category (tubules 3/3, nuclear pleomorphism 3/3, mitotic count 2/3, total 8/9). There is no evidence of lymphovascular invasion or a DCIS component. Tumour infiltrating lymphocytes occupy less than 5% of the tumour stroma.

Conclusion :- Trucut biopsy of mass n the left breast.

1. Tumour type - Invasive breast carcinoma of no special type
2. Tumour grade - Nottingham (modified Bloom and Richardson) grade 2
3. Lymphovascular invasion - Absent
4. DCIS component - Absent



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HISTOPATHOLOGY

** OPB/AHH/ASH **

Page 2 of 2

UNIT : 120459082
 REFERENCE No. : 01 0328 02/01/25
 SAMPLE DATE & TIME : 02/01/2025 11:53
 REPORT DATE & TIME : 15/01/2025 16:58
 PATIENT : MRS. REHANA RAHMAN
 REFERRED BY : DR (MRS) LAKMALIE PARANAHEWA

AGE : 71 Y/F 17/08/1953

AHH2099932 / ASH5253

Comment :- Recommend receptor studies and HER2NEU on blocks PC 248, C, D & E.

PCH - 248
(S.C.T - 02/01/2025 at 10.50 am)

Chandu de Silva

PROP. CHANDU DE SILVA
MBBS, D. Path, MD (Histopathology), FRCR (Histopathology), FRCR (Histopathology), FRCR (Histopathology)
Professor of Pathology



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HISTOPATHOLOGY

** QPD/AHH/ASH **

Page 1 of 1

REF ID : 120459082
 REFERENCE No. : 01 0325 02/01/25
 SAMPLE DATE & TIME : 02/01/2025 11:53 AGE : 71 Y/F 17/08/1953
 REPORT DATE & TIME : 24/01/2025 11:05 AHH2099932 / ASH5253
 PATIENT : MRS. REHANA RAHMAN
 REFERRED BY : DR (MRS) LAKMALI PARANAHEWA

TEST : IMMUNOHISTOCHEMICAL ASSAY OF OESTROGEN RECEPTORS

ER - Positive - Allred score = 8/8
 Intensity score = 3/3
 Proportion score = 5/5

PR - Positive - Allred score = 7/8
 Intensity score = 3/3
 Proportion score = 4/5

Her2neu - Inconclusive (2+). (Incomplete and weak membrane staining)

Ki 67 - Proliferative index of 80%

Comment : Recommend FISH for Her2neu.

PC

Chandu de Silva

PROF. CHANDU DE SILVA
 MBBS, D.Path, MD (Histopathology), FCPATHSL, FCSSSL, MIAC
 Professor of Pathology



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ENZYME IMMUNOASSAY

** QPC/ANIVASH **

Page 1 of 1

ID : 120459082
 REFERENCE No. : 01 0201 02/01/25
 SAMPLE DATE & TIME : 02/01/2025 19:02
 REPORT DATE & TIME : 03/01/2025 16:01
 PATIENT : MRS. REHANA RAHMAN
 REFERRED BY : DR. MAHENDRA PERERA

AGE : 71 Y/F 17/08/1953

ARH2005804 / ASH2105889

TEST	RESULT	FLAG	REFERENCE VALUE
CA 15-3	36.40		u/ml

Comment :-

Expected value :

6.4 - 58

Median 21.6

Chelvan
MLT