MEDGENOME
CAP ACCREDITED
258/A, 3rd Floor, Narayana Nethralaya Building, Narayana Health City,
Hosur Road, Bommasandra, Bangalore, Karnataka, India - 560 099
(Toll Free) 1800 103 3691 techsupport@medgenome.com
www.medgenome.com customersupport@medgenome.com

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

ESR1 gene testing by NGS -Liquid Biopsy (Hot Spot Mutations)

Test Name:* Test Code:* MGM2732

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

Whole Blood in Streck Tubes 2x 10ml

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.

Patient Details

Name:* Mrs. G.Z.R. Ifhaam D.O.B. DD MM YY Age:* 67Y/F Gender:* M / F

(In Capital Letters)

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* 14/5/2025 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. MAHENDRA PERERA
MBBS (Ceyl), MD (Ceyl), DMRT
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:_____

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COLLEGE OF AMERICAN PATHOLOGISTS

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. G.Z.R. Ifhaam

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.

MeGenome may reserve the right to send you communications on genetics / genomics periodically. The team may also connect with you to seek consent for your active participation in certain programs & communications.

*Fields are mandatory

CONFIDENTIAL LABORATORY REPORT
Member of Clinical and Laboratory Standards Institute, U.S.A.

Asiri Hospital Holdings PLC, 181, Kirula Road, Narahenpita, Colombo 05
T. +94 11 452 3355-7 F. +94 11 452 3358/66 E. prlab@asiri.lk

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A Softlogic Group Company

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.

HISTOPATHOLOGY

UHID : 20034000
REFERENCE No. : 01 4120 22/09/17
SAMPLE DATE & TIME : 22/09/2017 18:21
REPORT DATE & TIME : 02/10/2017 18:00 ASH4505 / ASH4946
PATIENT : MRS. G.Z.R. IFHAAM [ROOM NO.719A]
REFERRED BY : DR INDRANI AMARASINGHE

** IP/AHH/ASH **
IP No. : ASH0119199
AGE : 59 Y

TEST : **HISTOPATHOLOGY REPORT**

Sentinal lymph node
Frozen cytology / smear - left breast three small lymph nodes.

Microscopy :- Smears reveal scattered population of small lymphocytes.
Malignant cells are not seen.

Conclusion :- Cytology of sentinal lymph node

- Malignant cells are not seen.
- Reactive lymph nodes.

GJ

DR. GEETHIKA JAYAWEERA
M.B.B.S., Dip. Path, M.D. (Histopath)
Consultant Histopathologist

www.asirihealth.com

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HISTOPATHOLOGY

** OPD/AHH/ASH **

REFERENCE No. : 01 0155 05/10/17
SAMPLE DATE & TIME : 05/10/2017 07:42 AGE : 59 Y
REPORT DATE & TIME : 11/10/2017 16:13 ASH4505 / ASH3973
PATIENT : MRS. G Z R IFHAAM 4121L22/09/
REFERRED BY : DR INDRANI AMARASINGHE

TEST : IMMUNOHISTOCHEMICAL ASSAY OF OESTROGEN RECEPTORS

.

	Percentage score	Intensity score	Total score	
OESTROGEN RECEPTORS	4	3	7	- Allred score
PROGESTERONE RECEPTOR	4	3	7	- Allred score

HER 2 NEU - Negative

Ki 67 - proliferative index 23%.

GJ - 155 (05/10/17)

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HISTOPATHOLOGY

UHID : 20034000
REFERENCE No. : 01 4121 22/09/17
SAMPLE DATE & TIME : 22/09/2017 18:22
REPORT DATE & TIME : 02/10/2017 18:14 ash4505 / ASH4946
PATIENT : MRS. G.Z.R. IFHAAM [ROOM NO.719A]
REFERRED BY : DR INDRANI AMARASINGHE

** IP/AHH/ASH **
IP No. : ASH0119199
AGE : 59 Y

TEST : HISTOPATHOLOGY REPORT

Specimen :- 1. Left breast.
2. Sentinal lymph node.

Macroscopy :- 1. Mastectomy specimen with nipple and areolar 18 x 10 x 12 cm.
Cut surface shows tumours 2.5 x 2 x 2 cm upper lateral quadrant. Deep margin 2 cm. Rest of the breast show sclerosis. Lymph nodes were not identified from the axillary fatty tissue.

2. Fibro fatty fragments 4 x 3 cm. Three small lymph nodes 1 x 0.2 cm, 1 x 0.5 cm and 1 x 0.5 cm.

Microscopy :- Specimen type
---
1. Left breast
2. Sentinal lymph node

Tumour type

Duct carcinoma.

Tumour grade Nottingham's

Tubule - 3
Nuclear pleomorphic - 3
Mitoses - 2
---
score 8

Nuclear grade - III

Tumour size

2.5 x 2 x 2 cm.

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IP No. : ASH0119199
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Insitu component

Insitu duct comedo necrosis.

Deep surgical margin

1.5 cm.

Nipple and areolar

Unremarkable.

Rest of the breast tissue

Fibroadenosis.

Lymph node status

Sentinal node

Three small nodes, free of tumour tissue.

Pathological tumour stage
---
pT2 N0 Mx

Suggest
---
receptor status ER, PR, HER 2.

GJH

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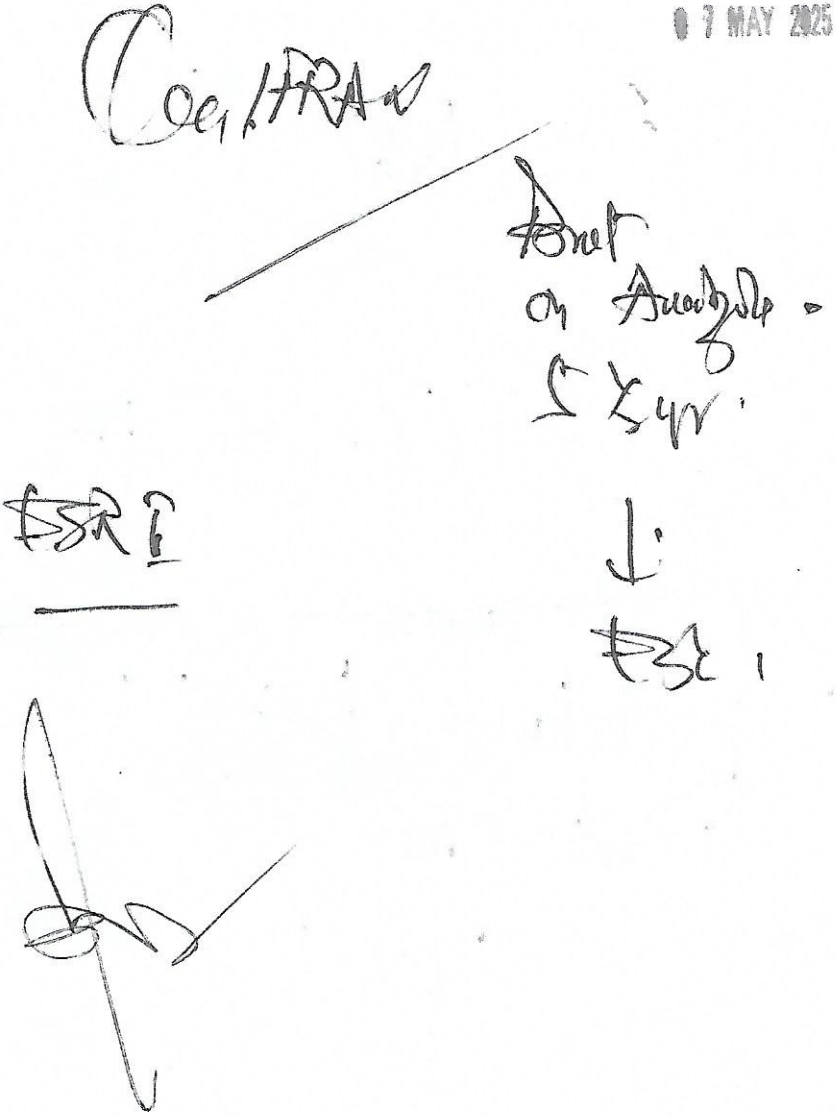
07 MAY 2025



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