

Sample Receipt Details:

POD : _____ Temp : _____
 Date & Time : _____ Sample Type : _____
 CS _____ Logistics _____
 Name & Sign : _____ 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
FISH for CLL Panel All markers (6)- Del6q, Del 17p, Del13q, ATM deletion/trisomy 11, Trisomy 12, IGH rearrangement)
Comprehensive molecular work-up for CLL Prognostication [NGS,Sanger,FISH]

Test Name*: _____

Test Code*: _____

MGM1276 , MGM1362

Sample type:

- | | | | |
|----------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input checked="" 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 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 |

Peripheral blood (5 ml in Heparin + Peripheral blood (5 ml in EDTA)

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. I. Kathriarachchi**
(In Capital Letters)

D.O.B. DD MM YY

Age*: **65Y/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* **25/03/2025**

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 (Gen), MD (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.

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. I. Kathriarachchi

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. Karla Arce, MD

Q. MAM - ~~1276~~
1276
MUA - 1362

[Tell
on Spine
Neurove]

(Chronic Leukemia)

Q
MUA

0777-361457

DR. MAHENDRA PERERA
MD, FRCS (S), FRCR
Consultant in General Surgery
& Hepato-Biliary
Pancreatic Surgery, Colombo 10, Sri Lanka

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Asiri Hospital Holdings PLC, 181, Kirula Road, Narahenpita, Colombo 05

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AUTOMATED COUNT

** RET/AHH/ALS **

Page 1 of 1

REFERENCE No. : 01 9540 05/02/25
 SAMPLE DATE & TIME : 05/02/2025 18:37 AGE : 65 Y/F
 REPORT DATE & TIME : 05/02/2025 18:49 AHH2010190 / AHH8876
 PATIENT : MRS. INDRANI KATHRIARACHCHI (566 05/02/25)
 REFERRED BY : DR EUGENE COREA
TEST/PROFILE : COMPLETE BLOOD COUNT .

TEST	RESULT		FLAG	REFERENCE VALUE
TOTAL WHITE CELL COUNT.	36.5	10 ⁹ /L	H	4.0 - 11.0
<u>DIFFERENTIAL COUNT.</u>				
NEUTROPHILS	18.0	%	L	40%-80% (2.0-7.0)
LYMPHOCYTES	41.0	%	H	20%-40% (1.0 - 3.0)
MONOCYTES	1.0	%	L	02%-10% (0.2 - 1.0)
EOSINOPHILS	0.0	%		01%-06% (0.02-0.5)
BASOPHILS	0.0	%		<0.1%-02% (0.02-0.1)
ATYPICAL LYMPHOID CELLS	40.0	%		
<u>HAEMOGLOBIN AND RBC PARAMETERS</u>				
HAEMOGLOBIN	11.2	g/dL	L	11.8 - 14.8
RED BLOOD CELLS	3.80	10 ¹² /L		3.8 - 4.8
MEAN CELL VOLUME	85.3	fL		76.0 - 96.0
HAEMATOCRIT	32.4	L/L (%)	L	36.0 - 44.0
MEAN CELL HAEMOGLOBIN	29.6	pg		27.0 - 33.0
M.C.H. CONCENTRATION	34.6	g/dL		32.0 - 36.0
RED CELLS DISTRIBUTION WIDTH	13.0	%		12.0 - 15.0
PLATELET COUNT	305	10 ⁹ /L		150 - 400
Smear Cells +				

MLT

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WESTERGREN METHOD

** OPD/AHH/ALS **

Page 1 of 2

UHID : 110242571
 REFERENCE No. : 01 0566 05/02/25
 SAMPLE DATE & TIME : 05/02/2025 16:52 AGE : 65 Y/F 22/05/1959
 REPORT DATE & TIME : 05/02/2025 20:49 AHH2010190 / ALS2011241
 PATIENT : MRS. INDRANI KATHRIARACHCHI
 REFERRED BY : DR EUGENE COREA

TEST	RESULT	FLAG	REFERENCE VALUE
ERYTHROCYTE SEDIMENTATION RATE 1st HOUR	11 mm		< 20

MLT

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CLINICAL CHEMISTRY

** OPD/AHH/ALS **

Page 2 of 2

UHID : 110242571
 REFERENCE No. : 01 0566 05/02/25
 SAMPLE DATE & TIME : 05/02/2025 16:52
 REPORT DATE & TIME : 05/02/2025 18:28 AHH2007780 / ALS2011241
 PATIENT : MRS. INDRANI KATHRIARACHCHI
 REFERRED BY : DR EUGENE COREA
 SAMPLE TYPE : Serum

TEST	RESULT	FLAG	REFERENCE VALUE
C.REACTIVE PROTEIN	3.7 mg/L		0.1 - 5.0

Comment :-

**** Ultra-sensitive CRP assay is now available.
 (Test code: B198)

MLT

Name of Patient :- Mrs. Indrani Kaththriarachchi
Referred By :- Dr. Mahendra Perera
UHID :- 210002650
Date :- 23-03-2023

US SCAN OF ABDOMEN AND PELVIS

Liver Normal in size. Echogenicity is normal.
No cyst or neoplasm in the liver.
No dilation of bile ducts.
Hepatic and Portal vein are normal.

Gall bladder Normal in size. No calculi.

Pancreas Normal in size & echogenicity. No masses.

Spleen Not enlarged.

Kidneys Both kidneys are normal in size and echogenicity. No hydronephrosis, calculi or evidence of renal parenchymal disease.

Bladder Normal outline. No bladder wall thickening, calculi, soft tissue masses.

Uterus is anteverted and normal in size. No uterine or adnexal masse.

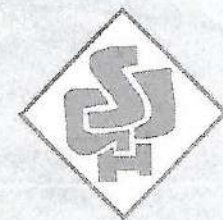
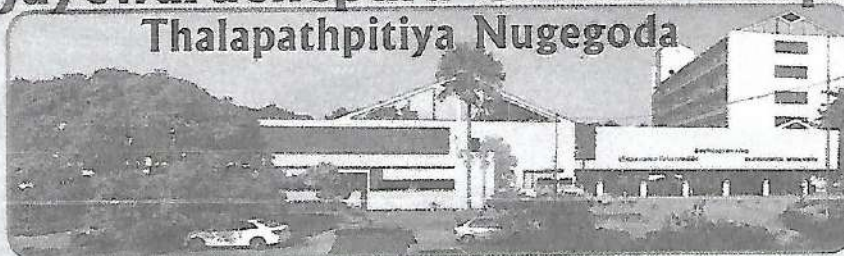
Free Peritoneal Fluid Nil

No abdominal lymphadenopathy.

Impression :-

Normal US scan of KUB & abdominal viscera.
Bowel pathology is not excluded.


Dr. Tamara Rajapakse
CONSULTANT RADIOLOGIST



An excellent health care with state responsibility

Tel:011-2778610 / Fax:011-2778622, Ext: Histology (3028), Bio Chemistry (3033), Hematology (3060), Microbiology (3036).
E-mail: srijayewardenepurahospital@gmail.com, Web: sjghsrilanka.org.

PATIENTS DETAILS -

PATIENT NAME - Mrs.I.Kathriarachchi
B.H.T. NO : - 6121003544
AGE - 61 Yrs
GENDER - Female
WARD - Private

SPECIMEN DETAILS

SPECIMEN TYPE - Peripheral blood
SPECIMEN NO. - 21F047
COLLECTED ON - 16.02.2021
RECEIVED ON - 16.02.2021
REPORTED ON - 16.02.2021

REFERRING DOCTOR Dr.Bhaddika Jayaratne (Consultant Haematologist)

FLOWCYTOMETRY

INDICATION - Treated as CLL ? Recurrence

LYMPHOMA PANEL B cells

CD 5	+
CD 10	Negative
CD 19	+
CD 20	++
CD 23	++
CD 38	Negative
CD 79b	+
FM7	++
CD 200	++
CD 43	Negative
smlg Kappa	++
smlg Lamda	Negative

COMMENT -

CD45 gated lymphoid cells of 56.3%
show strong kappa restricted

CD5 positive CD10 negative clonal

B cell proliferation.

CLL score less than 3 *

Differential diagnosis :

- 1) CLL atypical phenotype
- 2) Mantle cell lymphoma

Suggest:

- 1) Lymphnode biopsy/ bonemarrow biopsy with immunohistochemistry including Cyclin D1.
- 2) t (11;14)
- 3) Other relevant investigations

LYMPHOID SCREENING TUBE (LST) GATED IN CD45 REGION - 56.3 % LYMPHOID CELLS.

T CELLS - 19.1%
B CELLS - 78.2 %
NON T/B CELLS - 7.5 %

16.02.2021

Date

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

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

Medical Laboratory Technologist

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

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

DR(MS) C. KARIYAWASAN

Consultant

Dr. (Ms) Chitranga Kariyawasan

MBBS (MCOB) D Path

MD (Hematology)

Consultant Haematologist

MBBS, D. PATH, MD Hematology

Sri Jayewardenepura General Hospital

Nugegoda, Sri Lanka

Dr. (Mrs) Radhika T. Gnanadasa
Biochemist
B.Sc(Col), M.Sc (F.O.M. (Col), Adv. PGDMB,
Phd. (T.I.T.-Japan)

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ASIRI Laboratory Service

FLOW CYTOMETRY

REFERENCE NO : 1329L07/02/11
PATIENT NAME : Mrs. I. Kathirarachchi.
WBC COUNT : 30,800/ul
SPECIMEN : Peripheral Blood.
SAMPLE DATE : 07/02/11
REFERRED BY : Dr. Indira. Wijesiriwardena..(Cons. Haematologist)

B Lineage Markers

CD19	-	81%
CD20	-	83%
CD22	-	01%
CD23	-	81%
FMC7	-	03%
CD79b	-	84%
CD10	-	00%
Kappa (weak)	-	96%(of CD19 cells)
Lambda	-	01%(of CD19 cells)

T Lineage Markers

CD3	-	14%
CD5	-	73%

Non lineage Markers


CD103	-	01%
CD25	-	02%

Dual Markers

CD19+CD05	-	54%
CD19+CD10	-	00%

COMMENT:

Results are from a gate representing 71% of nucleated cells.
Immunophenotyping with available markers is most consistent with Chronic Lymphocytic Leukaemia.
Suggest correlate with clinical details and morphology


Dr. Lallindra Gooneratne
MD, FRCPATH(UK)
Consultant Haematologist

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BONE MARROW

LABORATORY REPORT

**** OPD/AHL ****

REFERENCE NO : 0290L13/02/11
DATE & TIME : Feb/15/2011 03:13 2586 / 1222
PATIENT : Mrs. INDRANI KATHRIARACHCHI 51Y (BLOOD P.0898L06)
REFERRED BY : DR INDIRA WIJESIRIWARDENA
TEST : BONE MARROW WITH TREPHINE BIOPSY

Trephine biopsy report

1.5 cm core of bone examined with 5 - 6 marrow pockets.
Normal trabeculae of bone.
Normocellular marrow spaces with a combination of a nodular and interstitial small lymphocytic infiltration.

No paratrabeculae infiltration of lymphocytes.
Erythropoiesis, granulopoiesis seem to be depressed.

Reticulin stain - Occasional fine individual fibres, with occasional foci of fine fibre network. Grade 1 (normal)
No necrosis or granulomata.

Comment : Findings with immunophenotyping of peripheral blood is in keeping with a chronic lymphocytic leukaemia.

Plw Haematology
Dr. Indira Wijesiriwardena
DR. INDIRA WIJESIRIWARDENA
MBBS, D.Path, MD Pathology (Haematology), FSLCH
Consultant Haematologist / Pathologist

Rf. to Medical Oncologist.
Ref. letter given to Dr. Delu Gunasekera

Dr. Delu Gunasekera
Dr. Bawandana
MBBS, MSc (Surg), FRCGS
Dip in Laparoscopic Surgery (France)
Senior Lecturer in Surgery &
Consultant Surgeon

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BONE MARROW

LABORATORY REPORT

** OPD/AHL **

REFERENCE NO : 0290L13/02/11
DATE & TIME : Feb/15/2011 03:13 1836 / 1222
PATIENT : Mrs. INDRANI KATHRIARACHCHI 51Y (BLOOD P.0898L06
REFERRED BY : DR INDIRA WIJESIRIWARDENA
TEST : BONE MARROW WITH TREPHINE BIOPEY

BONE MARROW REPORT

Bone Marrow Aspiration - Preliminary report

Indication - Loss of weight. Recurrent URTI
Lymphocytosis $25 \times 10^9 / L$

Hb = 11 WBC = $37 \times 10^9 / L$ Lymphocytes = 83%
Platelets = $273 \times 10^9 / L$

Blood Picture - Normochromic normocytic rbc.
Moderate mature lymphocytosis.
No prolymphocytes.
Platelets adequate.

Bone Marrow - Easy aspiration from right posterior
superior iliac spine.

Mildly hypocellular marrow fragments with cellular
cell trails.

Erythropoiesis - Appear depressed with normoblastic
maturation.

Granulopoiesis - Appear depressed.
Few myelocytes, metamyelocytes seen.

Thrombopoiesis - Normal numbers of megakaryocytes seen,
with normal morphology.

Marrow infiltrated 80 - 90 % by mature small lymphocytes.
Blast cells < 5 %

Contd....

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BONE MARROW

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PATIENT : Mrs. INDRANI KATHRIARACHCHI 51Y (BLOOD P.0898L06)
REFERRED BY : DR INDIRA WIJESIRIWARDENA

TEST : BONE MARROW WITH TREPHINE BIOPSY

Iron stores : Trace Grading 1+

Comment - Findings are in keeping with a chronic lymphoproliferative disorder: together with immunophenotyping results on peripheral blood a Chronic lymphocytic leukaemia is most likely.

Awaiting trephine biopsy processing for conclusive reporting.

LL

DR. INDIRA WIJESIRIWARDENA
MBBS, D.Path, MD Pathology (Haematology), FSLCH
Consultant Haematologist / Pathologist

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BONE MARROW

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Comment : Findings with immunophenotyping of peripheral blood is in keeping with a chronic lymphocytic leukaemia.

Plw H... ..

Dr. Indira Wijesiriwardena

DR. INDIRA WIJESIRIWARDENA
MBBS, D.Path, MD Pathology (Haematology), FSLCH
Consultant Haematologist / Pathologist

*Ref- to Medical Oncologist.
Ref- letter given to Dr. Delu Gunawardena*

Dr. Bawani...
MBBS, MRCP (UK)
Dip in Laparoscopic Surgery (France)
Senior Lecturer in Surgery &
Consultant Surgeon