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

BRCA1 & BRCA2 with HRR genes for somatic mutation testing

Test Name:* _____ Test Code:* MGM1623

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), specifiy tissue:_____
- ☒ FFPE tissue Block (Block no. .....)
- ☐ Fresh Frozen Tissue
- ☐ Saliva
- ☐ Other sample type (specify site) _____
- ☐ DBS/FTA

AS87A/24
AS87C/24

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:* Mr. M.D Albert Dede (In Capital Letters) D.O.B. DD MM YY Age:* 71Y/M 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* DD MM 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.

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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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. M.D Albert Dede

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

ASIRI SURGICAL HOSPITAL | AOI AMERICAN ONCOLOGY INSTITUTE PRECISION CANCER CARE

Comprehensive Cancer Care Centre

0 6 JAN 2025

Dr. MAHENDRA PERERA
MBBS (Cey), MD (Col), Dip RT
Consultant in Clinical Oncology
& Radiotherapy
Principal Investigator - Clinical Trials

Asiri AOI Cancer Centre (Private) Limited.
No.21, Kirimandala Mw, Colombo 5 T. +94 11 452 4400 E. asiriaoi@asiri.lk

NFTH Dr. Neville Fernando Teaching Hospital

Dr. Neville Fernando Teaching Hospital

CONFIDENTIAL LABORATORY REPORT

Patient Name	: M.D.ALBERT BEDE		
Reference No	: IP0019/201224		
Referring Dr.	: Dr. Prabath Pathirathna		
Gender	: M, 81 YR	**BHT No**	: 24K05703
Received On	: 20-Dec-2024 1:17 pm	**Room No**	: R433
Reported On	: 28-Dec-2024 12:53 pm	**Current Location**	: R433
Specimen	: SPECIMEN		

Histology Large sample

Histopathology Report

Specimen : TURP

Macroscopy : Multiple prostatic chips together measuring 46 x 46 x 3mm.

Microscopy : Sections from all chips show acinar adenocarcinoma showing glandular pattern to increasinglly complicated glandular proliferation to almost no glandular. Sheets and single cells. Perinural invasion noted.
Primary Gleason Grade 4
Secondary Gleason Grade 3
Gleason score 4 + 3 = 7
Grade group - 3

Conclusion : Prostatic adenocarcinoma with perineural invasion
Gleason score 4 + 3 = 7
Grade group - 3

Dr. Ananthie Samarasekara
MBBS Dip in path MD (Histopathology)
Consultant Histopathologist
AS 87/24

DIAGNOSIS CARD

O Natrilix SR 1.5mg mane
O Cilacar 10mg mane
O Cilacar 5mg mane nocte
O Atorva 10mg nocte
O CAD D 1000IU mane
O Levothyroxine 150mcg mane
O Paracetamol 1g tds
O Tranexamic acid 500mg tds X 5 doses

TURP done by Dr.Prabath Pathirathna(Con.Genitourinary surgeon) on 20/12/2024 under SA
Histology sent.
Post Op -
IV Broadced 1g bd
O Paracetamol 1g tds

Condition On Discharge -
PR 88bpm, BP 160/80mmHg

Discharge Plan -
O Tranexamic acid 500mg tds x 4 tabs
O Augmentin 625mg tds x 5 days
O Urimax 0.4mg nocte x 1/52
O Telmisartan 40mg mane x 2/52
O Natrilix SR 1.5mg mane x 2/52
O Cilacar 10mg mane x 2/52
O Cilacar 5mg ~~mane~~ nocte x 2/52
O Atorva 10mg nocte x 2/52
O CAD D 1000IU mane x 2/52
O Levothyroxine 150mcg mane x 2/52

Trace histology report.
R/V On Tuesday(24/12/2024) for catheter removal.~~(+or irrigation)~~
R/V Dr. Prabath Pathirathna(Con.Genitourinary surgeon) in 1/52.
If bleeding at home need to get readmitted to the hospital.(for irrigation)

Prepared By Dr.

NH 01

Dr. Neville Fernando
Teaching Hospital

93160

DIAGNOSIS CARD

NAME	: M.D.ALBERT BEDE	AGE	: 81 SEX Male
BHT NO	: 24K05703	CONSULTANT	: Dr. Prabath Pathiratna
DATE OF ADMISSION	: 20-December-2024	DATE OF DISCHARGE	: 22-December-2024

URETHRAL DILATION + TRANSURETHRAL RESECTION OF THE PROSTATE DONE ON UNDER SA 20/12/2024

C/O - AAR for UD+ TURP
Background - Difficulty in passing urine, Poor stream

PMHx - HTN +
PSHx - Circumcision done under LA
Allergies - No known allergies

Condition On Admission -
Well looking, Conscious & rational, Hydration good, Capillary refill good.
O/E - Afebrile , PR 68bpm, BP 150/78mmHg ,
Lungs clear, Abdomen soft

Investigations :
CBS - 113 mg/dl
FBC - Hb 13.2 g/dL , RBC 4.31 UL , HCT 40.6% , WBC 4.58 , PLT 232
APTT patient - 36.1 sec
APTT control - 34.0 sec
Prothrombin time - 11.2 sec
INR - 0.92
Blood group - O Positive

Inward Management
STAT doses -
IV Tranexamic acid

Regular doses -
IV Broadced 1g bd x 2 days
IV Vit.K 10mg daily x 2 days
O Telmisartan 40mg mane