CORE DIAGNOSTICS™

Test Requisition Form

12th November 2024

Accessioning ID

TRF No. : 1080714

PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Date of Birth / Age: 60Y/F

Gender ☐ Male ☐ Female

First Name: Mrs. S.C.A. Makalanda

Last Name: Colombo - Sri Lanka

Address:

PIN Code:

Contact Number:

Email ID:

Do you want us to send report & block at above given address ? ☐ Yes ☐ No

Do you want us to send report at above given email-id ? ☐ Yes ☐ No

If No, please specify:

PHYSICIAN INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Name: Dr. Mahendra Perera

Speciality: Consultant Clinical Oncology & Radiotherapy

Address:

PIN Code: Dr. MAHENDRA PERERA

Contact Number: MBBS (Cey), MD (Col), Dip RT

Email ID: Consultant in Clinical Oncology

Hospital / Institution Name: & Radiotherapy

Institution Code : IN10392

PHYSICIAN CONSENT

I certify that the patient has been informed of the benefits, risks, and limitations of the tests requested, informed the patient of the availability of genetic counselling, and have obtained informed consent from the patient for the tests requested.

Signature and Stamp of the Physician

PATIENT HISTORY (TO BE FILLED IN CAPITAL LETTERS ONLY)

Clinical History Attached	☐ Yes	☐ No
History of Smoking	☐ Yes	☐ No
Past History of Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Drug Intake if Any	☐ Yes	☐ No

If any, Name of the Drug ..... Amount and Time of Dose.....

Radiological / Endoscopic findings:

Other Relevant History:

Repeat Sample, If Yes, Please share old case number:

FOR GYNECOLOGICAL CYTOLOGY

Previous Cytology / PAP Reports Yes_____ No _____

Last Menstrual Period (LMP)

Details of Hormonal Status

Details of Hormonal Therapy

Details of Contraception

Details of Previous Surgery

PATIENT CONSENT

My healthcare provider has provided me with information regarding the tests requested on this form and advised me of the availability of professional genetic counselling. I confirm that the details provided on the form are correct and I have been informed of the benefits, risks, and limitations of the tests requested. I understand the implications of the information provided on the TRF on the test results. I have read and am aware of the conditions of reporting mentioned on the TRF. I give my consent that upon completion of the test, the remaining sample and test data may be "de-identified" and CORE Diagnostics may use this sample and test data for quality improvement, and/or research studies.

Signature/Thumb Impression of Patient

MODE OF PAYMENT (TO BE FILLED IN CAPITAL LETTERS ONLY)

☐ Cash ☐ Cheque ☐ DD

☐ Credit / Debit Card ☐ NEFT / RTGS ☐ Client Billing

For Client Billing:

Client Name: Aegle Omics Private Limited

Client Code: CL02611

For Others:

Transaction ID/Receipt No.:

Amount Paid:

TEST REQUIRED (TO BE FILLED IN CAPITAL LETTERS ONLY)

Test Code	Test Name
AO1175	CA 15.3
AO2904	CA 27.29
	5 mL Serum for broth tests)
	1 tube

SPECIMEN DETAILS

Specimen Type	No.	Specimen Type	No.
FFPE Block	S1	Aspirate Material	S13
Whole Blood EDTA / ACD / Fluoride / Heparin / Sodium Citrate	S2	Plasma EDTA/ Fluoride / Citrate	S14
Urine 1st Morning / Random Urine / 24 hrs Urine	S3	10% Buffered Formalin / Saline / Michel's media / Glutaraldehyde	S19
Cervical Scraping	S5	Bone Marrow Aspirate and Smear	S16
3-4 ml Bone Marrow / Peripheral Blood in EDTA	S6	Bone Marrow Biopsy	S17
3-4 ml Bone Marrow / Peripheral Blood in Sodium Heparin Tube	S7	Bone Marrow Aspirate / Biopsy	S18
10% Neutralised Buffered Formalin	S8	2 ml Serum from SST Tube	S15
7-10 ml Maternal Blood	S9	Fine Needle Aspirate	S20
Buccal Swab	S10	Sputum	S21
Biopsy Small / Medium / Large / Radical	S4	Stool	S22
Stained Histopathology Slides	S11	Bronchoalveolar Lavage (BAL)	S23
Body Fluids	S12	Others	S24

Bar Code	Specimen No.	Qty.	Identifcation No	Source Type
A.				
B.				
C.				
D.				
E				

COLLECTION DETAILS (FOR OFFICE USE ONLY)

Collection Date: _____ Collection Time: _____

Temperature at shipping: ☐ Ambient ☐ Refrigerated ☐ Frozen

Collection at: ☐ Hospital ☐ Lab ☐ Patient Home ☐ Walk in ☐ Others

Collection Address:

Collection ID:_____ POD_____

PHLEBOTOMIST INFORMATION (FOR OFFICE USE ONLY)

Name: _____

Sign.: _____

COREwings Barcode

ACCESSIONING DETAILS (FOR OFFICE USE ONLY)

To be filled by the Accessioning Officer (Mandatory)

Receiving Person:

Sign: _____ Date: _____ Time

Number of Samples:

Type of Sample

Receiving Temperature: ☐ Ambient ☐ Refrigerated ☐ Frozen

PATIENT/PHYSICIAN RECEIPT

Patient Name:

# of Samples Submitted:

Date of Submission:

Date of Birth/Age:

Test Name and Test Code:

TRF No: 1080714

Helpline No. : +91 88828 99999

Bangalore Lab : +91 8022244777 | Delhi Lab : +91 11 46269604

CORE DIAGNOSTICS™

ASIRI HOSPITAL | AOI

Comprehensive Cancer Care Centre

Dr. S.C.A Wickramasinghe

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