

**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**
**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 2 x 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 allogeneic bone marrow transplant: ☐ Yes ☐ No.

**Patient Details**

Name\*: **Mrs. S.C.A. Makalanda** D.O.B. **DD MM YY** Age\*: **60Y/F** Gender\*: **M / F**  
 (In Capital Letters)  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ E-mail I.D: \_\_\_\_\_

**Clinician Details**

Clinician's Name\*: **Mahendra Perera** Hospital Affiliation: **Agele 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.

**Dr. MAHENDRA PERERA**  
 MBBS (Ceylon College), 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. S.C.A. Makalanda

First Name

Middle Name

Last Name

Date of Birth: mm/dd/yyyy

Patient/Guardian Signature\*

Date:

Place:

Father Name

Mother Name

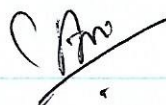
Signature\*

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.





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PROVIDING CANCER CARE

COMPREHENSIVE CANCER CARE CENTRE

10 NOV 2024

La Metolau

Dr. Mahendra Perera,

Dr. MAHENDRA PERERA  
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Consultant in Clinical Oncology  
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Principal Investigator - Clinical Trials