

CORE DIAGNOSTICS™

Test Requisition Form

9th September 2024

Accessioning ID

TRF No.: 1080714

PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)

Date of Birth / Age: 46Y/F

Gender: Male Female

First Name: Mrs. Chinthika, Pathiraja

Last Name: Colombo - Sri Lanka

Address:

PIN Code: 500001

Contact Number: 1111111111

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:

Dr. MAHENDRA PERERA

MBBS (Cey) MSc (Col) Dip RT

Consultant in Clinical Oncology

& Radiotherapy

Contact Number:

Email ID:

Hospital / Institution Name:

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
AO2904	CA 27.29

3 mL Serum from 1 SST, 2 mL (1 mL min.)

Serum from 1 SST

2 tubs

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.	Identification 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: COREwings Barcode

Sign:

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:

Helpline No.: +91 88828 99999

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

Date of Birth/Age:

Test Name and Test Code:

TRF No: 1080714

CORE DIAGNOSTICS™

6 Dec 2011

2011

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- 148

B11 Marcell + 0882

Breath + Apollo

* 08 Alo + pella

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

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