

# CORE DIAGNOSTICS™

## Test Requisition Form 2nd July 2024

TRF No. : 1080714

Accessioning ID

**PATIENT INFORMATION (TO BE FILLED IN CAPITAL LETTERS ONLY)**

Date of Birth / Age: 70Y/F  
Gender:  Male  Female  
First Name: Mrs. MHS Samarasinghe  
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. Wasantha Rathnayake  
Speciality: Consultant Clinical Oncology & Radiotherapy  
Address: \_\_\_\_\_  
PIN Code: \_\_\_\_\_  
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 LimitedClient Code: CL02611**For Others:**

Transaction ID/Receipt No.: \_\_\_\_\_

Amount Paid: \_\_\_\_\_

**TEST REQUIRED (TO BE FILLED IN CAPITAL LETTERS ONLY)**

Test Code	Test Name
NA3167	HRR Gene Panel (Germline + Somatic)
	Formalin fixed paraffin embedded tissue block
	Wax Block PG123A2b &A2c
	PG123A2b
	PG123A2c

**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: \_\_\_\_\_  
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: \_\_\_\_\_  
Helpline No. : +91 88828 99999  
Bangalore Lab : +91 8022244777 | Delhi Lab : +91 11 46269604

Date of Birth/Age: \_\_\_\_\_ TRF No: 1080714  
Test Name and Test Code: \_\_\_\_\_