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 : FFPE

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

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

-2* 10ml of Peripheral blood in Streck tube

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:* Mrs. Pubuduni Dahanayake (In Capital Letters) D.O.B. DD MM YY Age:* 59Y/F 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 20/08/2025

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.

MBBS (Cey), MD (Onc), 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: _____

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CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

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. Pubuduni Dahanayake

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

Dr. MAHENDRA PERERA
MBBS (Ceylon) MD (Gen) Dip ICT
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

NH 7

CONFIDENTIAL LABORATORY REPOR

Patient Name	: Mrs. D.P.DHANAYAKA		**Gender**	: F, 52 YR	
Reference No	: OP0037/010518		**Received On**	: 01-May-2018	9:55 am
Referring Dr.	: Dr. Mahendra Perera		**Reported On**	: 01-May-2018	11:30 am
			Specimen	:	

FNA

Cytopathology Report

FNAC done from both lesions.

Clinical History : Suspicious mass in left breast

Specimen : FNAC of left breast mass

Macroscopy : Five smears were examined.

Microscopy : Smears show poorly cohesive sheets of atypical duct epithelial cells with moderate nuclear pleomorphism , irregular nuclei and prominant nucleoli. No myoepithelial cells.

Conclusion : **FNAC of left breast mass**
C5 malignant.
Ductal carcinoma.

Prof. Kamani Samarasinghe
MBBS D Path MD (Histopathology)
Consultant Histopathologist
CYKS 75

M.L.T. .

5/1/2018 11:57:

Rm. 431

NH 01

Dr. Neville Fernando
Teaching Hospital
Caring hands Healing hearts

27451

DIAGNOSIS CARD

NAME : Mrs. D.P.DAHANAYAKE AGE : 52 SEX Female
BHT NO : ~~18E05877~~ CONSULTANT : Dr. K.S. Perera
DATE OF ADMISSION : 02-May-2018 DATE OF DISCHARGE : 05-May-2018

Left side Mastectomy and Level II axillary clearance

Blood Group-O positive

Done by- Dr.K.S Perera under General anesthesia by Dr.Mala Nanayakkara

Indication-Ductal Carcinoma

Left side Eliptiical incision made.
Mastectomy done.
Axilla disection done and structures preseved.
Level II axillary clearance done
Haemostasis achieved .Drain Applied
Skin sutured with 3.0 monocryl subcut
Sent for Biopsy

DR. K. S. PERERA
MBBS, M.S, DRCS (England)
Consultant Surgeon

DEPARTMENT OF RADIOLOGY- G. H. POLONNARUWA

SERIAL NO: - 435
NAME: - Mrs. Pubuduni Dahanayake AGE:- 58Yrs SEX:-Female
WARD/CLINIC: - Oncology BHT:- 96/18 DATE:-09/10/2024
INDICATION: - L/S Breast cancer; for follow-up.

RIGHT SIDE MAMMOGRAM

Both CC and MLO views done in right breast.

Right breast show fatty parenchymal architecture.
No evidence of definite mass lesions.
No malignant calcifications are seen.
Skin appears normal. No skin thickening.
Right nipple is seen in profile and appears normal.
Right areole, subcutaneous and retromammary fat layers appears normal.
Pectoralis major muscles appear normal in right side.
No evidence of abnormal right axillary lymphadenopathy.

USS RIGHT BREAST

All four quadrants, sub areolar regions and axillary folds are examined sonographically.

Right breast show fatty parenchymal echo texture.
No cystic or solid lesions are seen.
Nipple-areolar complex appear normal.
No evidence of dilated intra-mammary ducts.
No suspicious axillary lymphadenopathy.

IMPRESSION: -

- **Normal right side mammogram and USS of right breast.**

.....
Dr. Densil Gunasekara.
MBBS, MD(Radiology),
Consultant Radiologist.

Dr. DENSIL GUNASEKARA
MBBS (Col), MD (Radiology)
Consultant Radiologist
Teaching Hospital - Polonnaruwa