MOLQ™ LABORATORY

TEST REQUISTION FORM

Patient Details

First Name: Dr Ajay Kumar Last Name: Dhar

Age: 67 yrs Gender: Male ☑ Female ☐

Address: 6-B, Mansarovar Apts

Sec-61, Noida Contact No.: 9818797547

E-mail ID AJAYPOORNIMA68@GMAIL.COM

Referred by Dr Vikas Contact No.:

For Maternal Screening - Date of Birth :- D D M M Y Y Y Y

Weight: ____kg. Height: ____ ft ____inches, LMP ____ Last Ultrasound Report

Billing Information

Client Name: Home Collection

Client ID:

Total Amount: 25000/-

Amount Received: ____ Receipt No.: ____

Amount Balance / Due:

Payment via: ☐ CASH ☑ CHEQUE ☐ CREDIT

Specimen Type Received (For MolQ use only)

☐ Serum	☐ Bone Marrow	☐ CSF
☐ Plasma: EDTA/FL/CIT	☐ FN Aspirate	☐ Fluid
☐ SST	☐ Tissue Formalin	☐ BAL
☑ W. Blood EDTA (2)	☐ Paraffin Block	☐ Sputum
☐ W. Blood Fluoride	☐ Smear	☐ Urine
☐ W. Blood Heparin	☐ Slide (H&E)	☐ Stool
☐ W. Blood Sodium Citrate	☐ Pus	☐ Swab
	☐ Blood Culture Bottle	☐ Others

Other Sample Type / Source:

Received Specimen Information (For MolQ use only)

Temperature: ☐ Ambient ☐ Refrigerated ☐ Frozen

Date: ____ Time: ____

Patient ID ____ No. of vials/container ____

1	2

Signature of Accessioning Officer(s)

Test Name/Test Code

(Please refer to the Directory of Services for correct name and specimen type)

Hereditory Cancer Panel

Instructions to Laboratory/Clinical Information

Sent Specimen Information

Temperature: ☐ Ambient ☐ Refrigerated ☐ Frozen

Sample / Vial Type	Vial ID Barcode
E	MolQ 10324915
S	

Total No. of Vials/Container ____

Specimen Collection Information

Date: 20/1/18 Time: 11:10

Fasting: Yes ☐ No ☐ Fasting Period: ____ Hrs.

Collection by: Gopi

Urine Volume: ____ ml Hrs. ____

Patient Consent : I hereby authorize MoLQ Laboratory to use and share with affiliates my personal information including but not limited to any condition / disease information etc. as may be necessary to perform the test or services etc. Medical records/information, to the extent of the applicable by laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate research and in future research of any kind and at any time in the future. The samples will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of any publication by MoLQ Laboratory, patient's identity will remain confidential. I agree to this access of my medical records and specimen for diagnostic and research purpose.

Disclaimer : For any test/service related complain/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Dehradun, Uttrakhand. The financial liability or compensation of any sort is not more than MRP of the Test requested.

रोगी सहमति : मैं मोल्क्यु प्रयोगशाला को अधिकृत करता हूँ कि मेरी पूर्ण व्यक्तिगत जानकारी अपनी किसी भी शाखा के साथ साझा कर सकती है। मेरी बीमारी की हालत या सूचना का खुलासा अगर परीक्षण के संचालन के लिए आवशयक है, तो मैं इसकी अनुमति देता हूँ यद्यपि यह जानकारी उस सीमा तक साझा की जाए जो कि कानूनी सीमा के अंतर्गत हो। मेरी इस प्रकार की जानकारी को पूर्ण रूप से गुप्त रखा जाए और सार्वजनिक रूप से उपलब्ध ना कराई जाए। इसके पश्चात मैं प्रयोगशाला को देबारा अधिकृत करता हूँ कि जो नमूना जाँच के लिए उपलब्ध करवाया था, उसमे से बचे हुए नमूने को प्रयोगशाला कभी भी और किसी भी समय किसी भी प्रकार के प्रयोग के लिए उपयोग में ला सकती है। शेष नमूने को पूर्ण रुप से अंकित किया जाए और गुप्त रुप से रखा जाए, जब इसको नष्ट किया जाए तो पूर्ण रुप से नियम और विनियमता का उपयोग किया जाए। किसी भी प्रकार के मोल्कयु प्रयोगशाला के प्रकाशन में रोगी की निजी जानकारियों को पूर्ण रुप में गुप्त रखा जाएगा। मै सहमत हूँ कि मेरी मेडिकल रिकॉर्ड और मेरे बचे हुए नमूने को नैदानिक प्रयोग और किसी भी प्रकार के अनुसंधान के लिए उपयोग में लिया जा सकता है।

अस्वीकृति : किसी भी जाँच सम्बन्ध शिकायत या जानकारी हेतु आप मोल्क्यु प्रयोशाला को सम्पर्क कर सकते है, किसी भी प्रकार की कानूनी झगड़े हेतु हमारा मुख्यालय देहरादून, उत्तराखंड है, किसी भी जाँच का मूल्य उसके दिए अधिकत्तम फुटकर मूल्य से अधिक नहीं होगा।

Patient/Client /Doctor's Signature

Date: .....

For any query reach us at contact@molq.in; Customer care 9999 778 778; Laboratory 0124-4307906

For more info Log on to: www.molq.in

9818797543

Fortis Escorts
HEART INSTITUTE

ESCORTS HEART INSTITUTE AND
RESEARCH CENTRE LIMITED
Okhla Road, New Delhi - 110025 (INDIA)
Phone : +91 11 47135000
Fax : +91 11 2682 5013
Mobile : +91 9818797543
E-mail : ajaypoornima6b@gmail.com
Website : www.ehirc.com

DR. AJAY KUMAR DHAR
M.D.
ASSOCIATE DIRECTOR
DEPARTMENT OF ANAESTHESIOLOGY

CASE HISTORY-

67 Year, Diabetic for 3 years, recently detected Hypertension

23/08/2014- Pain in central abdomen, USG done next day showed a PANCREATIC MASS with S.O.L in Liver , CA 19.9 was 1405.67

23/08/2014- CT Scan confirmed the USG findings & PET Scan was advised

24/08/2014- PET Scan was done (report attached)

26/06/2014- USG guided FNAC was done (report attached)

27/08/2014- USG Liver Biopsy was performed which confirmed Adenocarcinoma(High Grade)

28/08/2014- Surgical opinion was sought, it was inoperable because of nature of tumor & secondary's

29/08/2014- 6 Cycles of Palliative Chemotherapy started with Inj Gemcitabine 1600 mgs & Abrexin 200 mgs On Day 01,08,15 basis

15/11/2014- PET Scan done showed near complete metabolic response

28/02/2015- chemotherapy 6 cycles completed CA 19.9 was 1.20 and was advised CA 19.9 every month for 3 months

31/05/2015- Had again mild abdominal discomfort, CA 19.9 (34.0)Showed rising trend but PET Scan was normal, CA 19.9 kept on rising (184) and a repeat PET was done on07/07/2015 it was also reported normal, the CA19.9 continued to rise (740.0)

09/09/2015- In view of increased CA 19.9 (1550.0) a PET Scan was done which showed progressive - Disease in 4 Para aortic lymph nodes

NABH Accredited

Fortis Escorts
HEART INSTITUTE

ESCORTS HEART INSTITUTE AND
RESEARCH CENTRE LIMITED
Okhla Road, New Delhi - 110025 (INDIA)
Phone : +91 11 47135000
Fax : +91 11 2682 5013
Mobile : +91 9818797543
E-mail : ajaypoornima6b@gmail.com
Website : www.ehirc.com

DR. AJAY KUMAR DHAR
M.D.
ASSOCIATE DIRECTOR
DEPARTMENT OF ANAESTHESIOLOGY

09/09/2015- 6 bi monthly Cycles of FOLFIRINOX chemo therapy (Irinocam-180 mgs, Oxaliplatin 180mgs Leucovarin-400mgs, 5-Fluorouracil 400mgs stat & 2400 mgs over 46 hrs)

18/11/2015- Repeat PET Scan showed near complete metabolic response

21/04/2016- The chemotherapy finished and was advised CA19.9 every month

WAS symptom free for this intervening period

09/01/2017- Without having any symptoms the monthly marker showed again rising trend (60.0) & PET Scan was advised which revealed progression of disease

12/01/2017- Surgical review was sought for Pancretectomy but was refused this time also

17/01/2017- 6 cycles of Chemotherapy was again started with Inj Gemciatabine 1600 mgs & Nab-Paclitaxil 200mgs On 01,08,15 days protocol

During the chemotherapy period the marker CA 19.9 showed downward trend

29/07/2017- The chemotherapy finished and PET Scan one month later was normal (report attached)

31/08/2017- Keeping in view the repeated recurrence it was advised to have oral Chemotherapy (as maintenance) with Tablet Erlotnin 150 mgs(Erlonat-150) OD, This is still continuing but the marker has shown again rising trend(48.7), planned a PET Scan for 15th December 2017

During all this time I have been active, attending my routine day to day work

MOLQ Personalized Medicine Delivered...

Reference Laboratory
28-29, Sector 18 (P)
Gurgaon - 122015

Phone 0124 4307906
Fax 0124 4278596
Web www.molq.in

INFORMED CONSENT FOR GENETIC TESTING

I understand that my physician has ordered genetic testing. I understand that biological samples will be collected using generally accepted techniques; the risk(s) of which I have been separately informed. I understand that testing of my sample(s) will be limited to the research tes ordered by my physician. I understand that the sample(s) will be used for the purpose of attempting to determine if I and/or my family member have a mutation(s) in the disease gene(s). Results may indicate affected status, increased risk to someday be affected with and reproductive risk for this disease.

I understand that:

1) There are several categories of test results that may be reported including:
   a) A clinically significant abnormality IS detected, known to be associated with a targeted therapy or prognosis.
   b) A clinically significant abnormality **IS NOT** detected, however the clinical diagnosis may still be correct. This event may be due to medical science's current lack of knowledge of all the gene(s) involved with the disease or the inability of the current technology to identify certain types of mutations in the gene(s) which cause the disease.
   c) A result of uncertain clinical significance is detected. Additional testing of the patient and/or other family members may be recommended to help determine the significance of the result.
   d) Unexpected test result may be detected .These results may occur with screening tests that evaluate many different genetic regions. Although special measures are taken, samples mix up rare possibility.
2) An error in the test interpretation may occur if the true biological relationships of the family members being tested are not as stated. For example, a sequence change or deletion or duplication detected in an affected individual but not detected in the parents may be interpreted as a clinically significant change, but this interpretation is wholly dependent on the testing of the biological parents. If the stated father of an individual is not the true biological father, the interpretation may be incorrect. Then the germ line mutation could be missed in hereditary cancers. On rare occasions, the laboratory may obtain a result that suggests non-paternity and it may be necessary to report this to the physician who ordered the testing.
3) This consent form should not be used for prenatal diagnosis. For these cases, we require that the referring professional consult directly with our laboratory regarding all the sample and paper work requirement. Specific consent forms may also be required.
4) Genetic tests are relatively new and are being improved and expanded continuously. The tests are not considered research but the appropriate means of evaluation at the time of testing will be followed. This testing is complex and utilizes specialised material so that there is always a very rare possibility that the test will not work properly or that an error will occur.
5) The laboratory does not return the remaining sample to individual or physicians; however in some cases, it may be possible to perform additional studies on the remaining sample. The request for additional studies must be made by the referring physician or other authorised healthcare professional and there will be an additional charge. Samples will be retained in the laboratory in accordance with the laboratory retention policy.
6) Samples may be used for future research with prior consent from you. I do understand that I have the right to withdraw this consent at any time, and the entity storing the sample shall promptly destroy the sample or portions thereof that have not already being used.
   The stored samples ☐ **may** be used for future research ☐ **may not** be used for future research
7) Because of the complexity of genetic testing and the implication of the test results, the medical report will only be communicated through the ordering physician. The results are confidential and will only be released to other medical professionals or other parties without your written consent. All laboratory raw data are confidential and will not be released unless a valid court order is received.
8) Results may have clinical or reproductive implications for my family members. In rare cases, persons with genetic diagnosis have experienced problems with insurance coverage, employment and other entities. Participation in genetic testing is completely voluntary. We understand that you may wish to obtain professional counselling prior to signing this consent form.
9) I understand that a positive test result is an indication that I or the individual(s) being tested may be predisposed to or have the specific disease or condition tested for and may wish to consider further independent testing, consult my or his/her/their physician or pursue genetic counselling.
10) My signature below acknowledges my voluntary participation in this research test. The future use of your sample in the research may result in new products, tests or discoveries which may have potential commercial value. Donors of samples do not retain any property rights to the materials. As such, you would not share in any financial benefits from these products, tests or discoveries.
11) **I consent for the genetic test** _____ **and have received a copy of this form.**

Patient/Guardian DR. AJAY. K. JHAR _____ _____ 20/01/2018
Name *Relationship with patient, if minor* *Signature/ Thumb Print* *dd/mm/yyyy*

STATEMENT OF PHYSICIAN/COUNCELOR: I have explained the genetic testing suitable for this individual and the individual had the opportunity to ask questions. I have addressed the limitations outlined above, answered this person's questions and obtained consent from the patient or the Legal guardian for this testing. I confirm that the individual has given consent willingly.

Physician _____ _____ _____
Name *Signature* *dd/mm/yyyy*