To: Brooke Buchanan[bbuchanan@theranos.com]

From: Daniel Edlin

Sent: Sun 12/27/2015 10:50:26 PM

Importance: Normal

Subject: Fwd: Messaging for VIP guest -

Received: Sun 12/27/2015 10:50:26 PM

FYI.

Sent from my iPhone

Begin forwarded message:

From: Elizabeth Holmes < eholmes@theranos.com>
Date: December 27, 2015 at 3:43:05 PM MST

To: Christian Holmes < com>, Sunny Balwani < sbalwani@theranos.com>

Cc: Daniel Edlin < dedlin@theranos.com > Subject: RE: Messaging for VIP guest -

You can say we do run those assays ,but were not able to run them on this sample, apparently due to a human error in sample handling. Invite him back to do these and more if he would like and tell him I have been looking forward to meeting him.

From: Christian Holmes

Sent: Sunday, December 27, 2015 11:24 AM

To: Elizabeth Holmes < eholmes@theranos.com >; Sunny Balwani < sbalwani@theranos.com >

Subject: Fwd: Messaging for VIP guest -

FYI - this is the doc eah met at Forbes conference and invited to do comparison. He was very pleasant in person but noted he intends to write about his experience and results

Sent from my iPhone

Begin forwarded message:

From: Daniel Edlin < dedlin@theranos.com Date: December 27, 2015 at 1:58:36 PM EST

To: Daniel Young dyoung@theranos.com, Christian Holmes cholmes@theranos.com

Cc: Brooke Buchanan <bbuchanan@theranos.com>

Subject: Messaging for VIP guest -

Hi Daniel and Christian,

Yesterday we sent his results from the study in which we compare finger-stick CTN results to venous results run at Theranos, ARUP, and UCSF.
We were unable to return 5 test results for the CTN for the following reasons:
1. Potassium, Chloride, and Sodium
 Sample became contaminated during centrifugation, making these results unreportable.
b. Root cause (from Tina) - The contamination of the CTN is not due to any human error. Both CTN samples were spun the exact same way per our SOPs, but on one of the CTNs, red blood cells had contaminated the sample during centrifuge / transfer into the transfer vessel. We don't know how or why this happened – this happened rarely when we ran patient samples since April. When we did reviews of these failed samples in the past, we saw a thinner gel layer than usual, but it wasn't the case for this sample.
2. Calcium, Total Protein
 a. these two results were statistically significantly too high relative to the venous report, and therefore Daniel recommended we did not report these.
b. Root cause – unknown, possible due to collection issue or sample handling issue.
In your experience with "lab escalate" situations or in conversations with physicians, do we have standard messaging that we use for similar instances like this? Do you have any recommendations for how to explain the above to ?

Once we come to a consensus recommendation for messaging among the people on this email, I will notify SB/EH and follow up with on the phone.	
nothly 36/Err and lonow up with	on the phone.
Thanks,	
Dan	
Dali	