Ambry Genetics

Specific Site Analysis Test Requisition Form - Page 1 of 2
(Known Familial Alteration Analysis)

COMPLETE ENTIRE FORM TO AVOID DELAYS

PATIENT INFORMATION

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

Name (Last, First, MI)	Sex at Birth ☐F ☐M	Date of Birth (MM/DD/YY)	MRN

Ethnicity: ☐ Asian ☐ Ashkenazi Jewish ☐ Black/African American ☐ White ☐ French Canadian/Cajun ☐ Hispanic/Latino ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Portuguese ☐ Unknown ☐ Other:

Address	City	State	Zip

Phone	Email	Preferred Billing ☐ Insurance ☐ Self-pay ☐ Institutional

SPECIMEN INFORMATION* (For phlebotomy service, select all services you are requesting)

Type(s) ☐ Blood (EDTA preferred) ☐ Saliva ☐ Cord Blood** ☐ DNA, Source: ☐ Other**: ☐ Personal history of allogenic bone marrow or peripheral stem cell transplant*

Collection Date	Specimen ID ☐ Send saliva kit to patient	Medical Record #

PRENATAL SAMPLES ONLY**

Sample type: ☐ Direct CVS ☐ Cultured CVS ☐ Cultured amnio ☐ POC ☐ Cultured POC | Gestational age at sample collection

** Blood/saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. See ambrygen.com/specimen-requirements for details.*

*** Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.*

Phlebotomy Services Request: ☐ Phlebotomy draw ☐ Send blood kit to patient^ ☐ Send saliva kit to patient

^As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.

INDICATION(S) FOR TESTING

ICD-10 code(s): | Testing could aid in systemic therapy and/or surgical decision-making for my affected patient ☐ Yes ☐ No

ORDERING LICENSED PROVIDER/SENDING FACILITY (Each listed person will receive a copy of the report)

Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone

Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email

ADDITIONAL RESULTS RECIPIENTS

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent.I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.

Signature Required for Processing Medical Professional Signature: Date:

☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Auth #

Out of Pocket:
In many cases, we will start testing immediately (may vary by test or insurance provider). We will attempt to contact the patient if the estimated out-of-pocket costs are > USD $100.

Special Billing Notes:

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*

Address

Contact Name

Phone Number	E-mail/Fax

☐ PATIENT PAYMENT

☐ Check (Payable to Ambry Genetics)
☐ Credit Card (Call 949-900-5795)

Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company.

For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambry's Patient Assistance Program**, please provide the total annual gross household income: $_____ and the number of family members in the household supported by the listed income: _____. I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

For NY Residents:
☐ I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Date:

Ambry Genetics®

Patient Name: _____ DOB: _____

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SPECIFIC SITE ANALYSIS (5555)

Positive control: ☐ Sent ☐ To be sent ☐ Not available ☐ Available at Ambry, accession #:

The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory:

1. Proband report (mandatory)
2. Positive control (recommended; required for prenatal testing)

ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence alteration. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.

ALTERATION TO BE TESTED	
Gene 1	Alteration 1
Gene 2	Alteration 2
Gene 3	Alteration 3
Gene 4	Alteration 4

PATIENT CLINICAL INFORMATION

☐ Healthy ☐ Affected/Symptomatic, age at diagnosis:

Please list relevant clinical findings with ICD-10 codes:

PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)

Previously Detected Alteration(s)	Gene Name	Testing Lab

Patient previously tested at Ambry? ☐ Yes ☐ No Family previously tested at Ambry? ☐ Yes ☐ No

Name	Date of Birth (MM/DD/YY)	Relation

FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED

Both test codes required for fetal specimens

☐ 1260 MCC for fetal specimen or cord blood ☐ 1262 MCC Reference for maternal blood sample (No Charge)

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