

GENERAL TEST REQUISITION

Arrows "▶" Mandatory for Processing

Patient Information

▶ DOB MM - DD - YEAR	▶ Last Name	▶ First Name	M Initial
▶ Gender <input type="checkbox"/> F <input type="checkbox"/> M	▶ Street Address, City, State, Zip		
▶ Ethnicity <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish (Ashkenazi) <input type="checkbox"/> Specify: _____	▶ Home Phone Work/Cell		

Specimen ▶ Collection Date: _____ Specimen ID: _____ MR#: _____ Specimen Type (See Requirements) <input type="checkbox"/> Blood <input type="checkbox"/> Blood Spot <input type="checkbox"/> DNA <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> Cultured CVS <input type="checkbox"/> CVS Tissue <input type="checkbox"/> Other: _____	Previous Test History Previously Detected Mutations: _____ Testing Lab: _____ Patient previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Relation: _____ Name: _____ Relation: _____ Name: _____ Relation: _____ Name: _____ Relation: _____
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Contact and Organization Information	
▶ Authorized Medical Professional	NPI#
▶ Ph	▶ FX
▶ Facility Name and Address	ID#

Additional Results Recipient
Medical Professional Name:
Facility Name and Address <input type="checkbox"/> Same As Above
Ph Fx

▶ Form Completed by	▶ Phone
By ordering testing, the medical professional or authorized person acknowledges the patient has been supplied information regarding genetic Testing and the patient has given consent for genetic testing to be performed. Does this patient give consent to the use of their sample for research? <input type="checkbox"/> Yes <input type="checkbox"/> No Consent is implied if a box is not marked Medical Professional Signature Mandatory for New York State X _____ Date	

▶ Indication for Testing (please list clinical findings) <input type="checkbox"/> Diagnostic <input type="checkbox"/> Carrier Screening <input type="checkbox"/> Research <input type="checkbox"/> Positive Newborn Screen <input type="checkbox"/> Family History <input type="checkbox"/> Other _____ ICD-9 Codes: _____	List Clinical Findings: Sweat Chloride: <input type="checkbox"/> nl (<40) <input type="checkbox"/> indeterminate (40-60) <input type="checkbox"/> elevated (>60) mmol/L:
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Laboratory Tests:	Imaging, Pathology, Biochemistry, Other:
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Billing Information - Mandatory For Processing

AMBRY GENETICS provides a selection of convenient billing options. Please choose an option below and supply all requested information for your billing option. Keep in mind that patient testing will be delayed until all of the billing requirements have been met. Choose an option below.

<input type="checkbox"/> Bill Facility	<input type="checkbox"/> same as ordering facility	<input type="checkbox"/> Bill Insurance Include card copy (both sides)	<input type="checkbox"/> Pre-Payment
Facility Name	Name of Insured	Relation to patient? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse	Payment Type <input type="checkbox"/> Check <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> Visa <input type="checkbox"/> American Express
Address, City, State, Zip	Insurance Company Name and Address		Card Number Exp Date
Contact Person	Insurance Phone		Cardholder Name Amount \$
Contact Person Phone	Member ID #	Group #	Signature Date
	Authorization #	Date	Patient Acknowledgement I hereby authorize my insurance benefits to be paid directly to Ambry Genetics Corporation and authorize them to release medical information concerning my testing to my insurer. I hereby acknowledge I am financially responsible for any amounts not paid by insurer. X _____ Date

MARK A TEST ON SUBSEQUENT PAGES FOR PROCESSING

Thank You for Choosing Ambry Genetics

▶ Test Directory		Gene Sequence Analysis (unless otherwise indicated)	
CANCER		DIAMOND-BLACKFAN ANEMIA (DBA)	
<input type="checkbox"/> 8500 Ambry SEQUENCE™: HNPCC (Complete pathway, steps 1-3) <ul style="list-style-type: none"> <input type="checkbox"/> 8504 Step 1 only (<i>MLH1</i> & <i>MSH2</i> gene sequence) <input type="checkbox"/> 8506 Step 2 only (<i>MLH1</i> & <i>MSH2</i> deletion/duplication) <input type="checkbox"/> 2244 Step 3 only (<i>MSH6</i> gene sequence) <input type="checkbox"/> 8502 HNPCC AMPLIFIED™ (<i>MLH1</i> , <i>MSH2</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 2200 HNPCC, <i>MLH1</i>-Related <input type="checkbox"/> 2220 HNPCC, <i>MSH2</i>-Related <input type="checkbox"/> 2240 HNPCC, <i>MSH6</i>-Related <input type="checkbox"/> 1685 Juvenile Polyposis, <i>SMAD4</i>-Related <input type="checkbox"/> 2680 Ambry SEQUENCE™: Multiple Endocrine Neoplasia Type2(<i>RET</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 2684 Step 1: 10,11,13-16 <input type="checkbox"/> 2686 Step 2: rest of gene <input type="checkbox"/> 2640 Multiple Endocrine Neoplasia Type1 (<i>MEN1</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 2360 <i>PALB2</i>-Related Pancreatic Cancer <input type="checkbox"/> 2100 <i>PTEN</i>-Related Disorders <input type="checkbox"/> 2766 Peutz-Jeghers AMPLIFIED (<i>STK11</i>) <input type="checkbox"/> 2760 <i>STK11</i> Gene Sequence Analysis <input type="checkbox"/> 2764 <i>STK11</i> Deletion/Duplication <input type="checkbox"/> 2600 Von Hippel-Lindau Disease (<i>VHL</i>) 	<input type="checkbox"/> 8540 Ambry SEQUENCE™: DBA (Complete pathway, steps 1-3) <ul style="list-style-type: none"> <input type="checkbox"/> 8542 Step 1 only (<i>RPS19</i>) <input type="checkbox"/> 8544 Step 2 only (<i>RPL5</i>, <i>RPL11</i>, <i>RPL35A</i>) <input type="checkbox"/> 8546 Step 3 only (<i>RPS24</i>, <i>RPS17</i>, <i>RPS7</i>) <input type="checkbox"/> 8547 Step 2 reflex to Step 3 <input type="checkbox"/> 2560 <i>RPS19</i> -Related DBA <ul style="list-style-type: none"> <input type="checkbox"/> 2460 <i>RPL5</i>-Related DBA <input type="checkbox"/> 2480 <i>RPL11</i>-Related DBA <input type="checkbox"/> 2500 <i>RPL35A</i>-Related DBA <input type="checkbox"/> 2580 <i>RPS24</i>-Related DBA <input type="checkbox"/> 2540 <i>RPS17</i>-Related DBA <input type="checkbox"/> 2520 <i>RPS7</i>-Related DBA 		
CHROMOSOMAL MICROARRAY ANALYSIS (aCGH)		DYSKERATOSIS CONGENITA (DC)	
<input type="checkbox"/> 6000 Ambry CMA: 105K Oligo Array	<input type="checkbox"/> 8160 Ambry SEQUENCE™: DC (Complete pathway, steps 1-3) <ul style="list-style-type: none"> <input type="checkbox"/> 8162 Step 1 only (<i>DKC1</i>, <i>TINF2</i> exon 6, <i>TERC</i>) <input type="checkbox"/> 8164 Step 2 only (<i>NHP2</i> exon 4, <i>NOP10</i> exon 2) <input type="checkbox"/> 2140 Step 3 only (<i>TERT</i>) <input type="checkbox"/> 1960 <i>DKC1</i>- Related Dyskeratosis Congenita <input type="checkbox"/> 1980 <i>TINF2</i>- Related Dyskeratosis Congenita <input type="checkbox"/> 2120 <i>TERC</i>- Related Dyskeratosis Congenita 		
CONGENITAL HYPERINSULINISM (CH)		FAMILIAL HYPERCHOLESTEROLEMIA	
<input type="checkbox"/> 8080 Ambry SEQUENCE™: CH (<i>ABCC8</i> , <i>KCNJ11</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 1384 <i>ABCC8</i> <input type="checkbox"/> 1340 <i>GCK</i> <input type="checkbox"/> 1370 <i>GLUD1</i> (Hyperinsulinism-Hyperammonemia) <input type="checkbox"/> 1364 <i>KCNJ11</i> 	<input type="checkbox"/> 8580 Familial Hypercholesterolemia Panel (<i>LDLR</i> , <i>partial APOB</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 8582 Familial Hypercholesterolemia AMPLIFIED™ (<i>LDLR</i>, <i>partial APOB</i>, <i>reflex to LDLR del/dup</i>) <input type="checkbox"/> 2780 <i>LDLR</i> Gene Sequence Analysis <input type="checkbox"/> 2784 <i>LDLR</i> Deletion/Duplication Analysis <input type="checkbox"/> 2800 <i>APOB</i> Partial Gene Analysis 		
CYSTIC FIBROSIS (CFTR) & PULMONOLOGY		GASTROENTEROLOGY	
<input type="checkbox"/> 1002 508 FIRST™ <ul style="list-style-type: none"> <input type="checkbox"/> 1006 CF AMPLIFIED™ <input type="checkbox"/> Report PolyT / TG Repeat Status <input type="checkbox"/> 1000 CF Gene Sequence Analysis <input type="checkbox"/> 1004 CF Deletion/Duplication <input type="checkbox"/> 1010 CF TG Repeat Analysis (Poly T Variant & TG Repeat) <input type="checkbox"/> 1300 <i>ABCA3</i> <input type="checkbox"/> 1140 Alpha-1 Antitrypsin Deficiency (<i>SERPINA1</i>) <input type="checkbox"/> 1580 Congenital Central Hypoventilation Syndrome (<i>PHOX2B</i>) <input type="checkbox"/> 8140 IPF Telomerase (<i>TERT</i>, <i>TERC</i>) <input type="checkbox"/> 8120 PCD 61 (<i>DNAH5</i> & <i>DNAI1</i> Mutation Panel) <input type="checkbox"/> 1540 Pulmonary Arterial Hypertension (PAH AMPLIFIED™ – <i>BMPR2</i>) <input type="checkbox"/> 1541 PAH Deletion/Duplication (<i>BMPR2</i>) <input type="checkbox"/> 1160 Surfactant Protein B (<i>SFTPB</i>) <input type="checkbox"/> 1180 Surfactant Protein C (<i>SFTPC</i>) Research Only - Please call before sending <ul style="list-style-type: none"> <input type="checkbox"/> 1020 Asthma (<i>ADRB2</i>) <input type="checkbox"/> 1280 Surfactant Protein D (<i>SFTPD</i>) 	<input type="checkbox"/> 8020 Pancreatitis Panel (<i>CFTR</i> , <i>PRSS1</i> , <i>SPINK1</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 8040 Pancreatitis AMPLIFIED™ (Panel + <i>CFTR</i> Del/Dup) <input type="checkbox"/> 1100 <i>PRSS1</i> <input type="checkbox"/> 1120 <i>SPINK1</i> <input type="checkbox"/> 1660 Chymotrypsin C-Related Pancreatitis (<i>CTRC</i>) <input type="checkbox"/> 1840 Wilson Disease (<i>ATP7B</i>) <input type="checkbox"/> 8602 Juvenile Polyposis AMPLIFIED™ (<i>BMPR1A</i>, <i>SMAD4</i>) <input type="checkbox"/> 8600 Juvenile Polyposis Deletion/Duplication (<i>BMPR1A</i>, <i>SMAD4</i>) <input type="checkbox"/> 2820 <i>BMPR1A</i> Gene Sequence Analysis <input type="checkbox"/> 1685 <i>SMAD4</i> Gene Sequence Analysis 		
DIABETES		GENETICS	
Neonatal Diabetes <ul style="list-style-type: none"> <input type="checkbox"/> 8062 Ambry SEQUENCE™: Neonatal Diabetes (<i>KCNJ11</i>, <i>INS</i>, <i>ABCC8</i>) <input type="checkbox"/> 1360 <i>KCNJ11</i> <input type="checkbox"/> 1620 <i>INS</i> <input type="checkbox"/> 1380 <i>ABCC8</i> <input type="checkbox"/> 1340 <i>GCK</i> (Neonatal) <input type="checkbox"/> 1400 <i>IPF1</i> (Neonatal) MODY <ul style="list-style-type: none"> <input type="checkbox"/> 9000 Ambry SEQUENCE™: MODY (<i>TCF1</i>, <i>GCK</i>, <i>HNF4A</i>) <input type="checkbox"/> 8300 MODY 1-3 Deletion/Duplication <input type="checkbox"/> 1504 <i>RCAD/MODY5</i> AMPLIFIED™ <input type="checkbox"/> 1510 <i>RCAD/MODY5</i> Deletion/Duplication <input type="checkbox"/> 1480 <i>HNF4A</i> (MODY1) <input type="checkbox"/> 1340 <i>GCK</i> (MODY2) <input type="checkbox"/> 1420 <i>TCF1</i> (MODY3) <input type="checkbox"/> 1400 <i>IPF1</i> (MODY4) <input type="checkbox"/> 1500 <i>TCF2</i> (MODY5) 	<input type="checkbox"/> 1640 Alagille AMPLIFIED™ (<i>JAG1</i>) <ul style="list-style-type: none"> <input type="checkbox"/> 1641 Alagille Deletion/Duplication (<i>JAG1</i>) <input type="checkbox"/> 1320 Aminoglycoside-Related Hearing Loss (<i>MT-RNR1</i>) <input type="checkbox"/> 8520 Ambry SEQUENCE™: Angelman Syndrome (<i>SNRPN</i>, <i>UBE3A</i>) <input type="checkbox"/> 2420 Angelman-like Syndrome (<i>SLC9A6</i>) <input type="checkbox"/> 1804 Ashkenazi Jewish FlexPanel™ with all 11 conditions <input type="checkbox"/> 1804 Ashkenazi Jewish FlexPanel™ as marked below <ul style="list-style-type: none"> <input type="checkbox"/> Bloom <input type="checkbox"/> GSD1a <input type="checkbox"/> Canavan <input type="checkbox"/> MSUD <input type="checkbox"/> CF <input type="checkbox"/> MLIV <input type="checkbox"/> Fam. Dysaut. <input type="checkbox"/> Niemann-Pick A <input type="checkbox"/> Fanconi An.-C <input type="checkbox"/> Tay-Sachs <input type="checkbox"/> Gaucher <input type="checkbox"/> 1040 Beta Thalassemia Plus (<i>HBB</i>) <input type="checkbox"/> 1220 Canavan AMPLIFIED™ (<i>ASPA</i>) <input type="checkbox"/> 2380 CHARGE Syndrome (<i>CHD7</i>) <input type="checkbox"/> 1720 Fabry Disease (<i>GLA</i>) <input type="checkbox"/> 2620 Familial Hypocalciuric Hypercalcemia (<i>CASR</i>) <input type="checkbox"/> 1820 Gaucher Disease (<i>GBA</i>) <input type="checkbox"/> 1600 Glutaric Acidemia Type 1 (<i>GCDH</i>) <input type="checkbox"/> 1880 Glycogen Storage Disease Type Ia (<i>G6PC</i>) <input type="checkbox"/> 1900 Glycogen Storage Disease Type Ib (<i>SLC37A4</i>) <input type="checkbox"/> 2746 The Ambry Test: HAE AMPLIFIED (<i>SERPING1</i>) <input type="checkbox"/> 2740 The Ambry Test: <i>SERPING1</i> Gene Sequence Analysis <input type="checkbox"/> 2744 The Ambry Test: <i>SERPING1</i> Deletion/Duplication Analysis <input type="checkbox"/> 2700 <i>RET</i>-Related Hirschsprung Disease <ul style="list-style-type: none"> <input type="checkbox"/> 2704 Step 1: exons 2,3,5,6,9,10,12,13,17 <input type="checkbox"/> 2706 Step 2: rest of gene 		

Patient Consent Molecular Genetic Testing

Test Purpose: The purpose of this molecular genetic test is to ascertain if I am, **my child** is, or **my unborn child** is [please circle appropriate] carrying mutation(s) predisposing to or causing the specific disease or condition: _____.
A supplemental disease description sheet is available from Ambry Genetics.

Test Method: The blood, body fluid, or tissue specimen submitted is required for isolation and purification of DNA for molecular genetic testing. The test will cover all disorders requested on the Ambry Genetics requisition form.

Test Results: I understand that due to the complexity of DNA based testing and the important implications of the test results, these results will be reported only through the patient's designated physician(s) or genetic counselor (where allowed) and that I must contact my provider to obtain the results of the test. The test results, in addition, could be released to all who, by law, may have access to such data.

I understand that if results of the molecular genetics tests are **positive**, I may be a carrier of, predisposed to, or have the specific disease or condition tested for and I may want to consider further independent testing, consult with my physician, or pursue genetic counseling. I understand that if results of the molecular genetics tests are **negative**, I may not be a carrier of, predisposed to, or have the specific disease or condition tested for and I may want to consider further independent testing, consult with my physician, or pursue genetic counseling. I understand the limitations of these results: the test results could be based upon probabilities, and may not provide a 100% definitive conclusion to either genetic disease predisposition or manifestations. I understand that the molecular genetic test may not generate results and that an additional blood, body fluid, or tissue sample may be needed to obtain accurate results. I understand that the molecular genetic test may not generate accurate results for the following reasons: sample mix-up, samples unavailable from critical family members, maternal contamination of prenatal samples, inaccurate reporting of family relationships, or technical problems, but not limited to these.

Ambry's Rights: Ambry reserves the right to: 1) suggest additional molecular testing if it would help in resolving the patient's clinical genotyping, 2) report additional testing results (other than requested) if they are clinically relevant to the patients and their families, and 3) refuse testing if one of the conditions in the Patient Consent form is not met.

Use of Specimens: After testing is completed, I understand that my blood, body fluid or tissue specimens may be disposed of or retained indefinitely for research, test validation, and/or education by Ambry Genetics, as long as my privacy is maintained. I understand that no compensation will be given nor will funds be forthcoming due to any invention(s) resulting from research and development using the specimens submitted. I understand that I may refuse to submit my specimen for use in this way and may withdraw my consent at anytime by contacting the medical director. I understand that my refusal to consent to medical research will not affect my results. Indicate consent or denial below. If a box is not marked consent is implied.

I consent to the use of my sample for research. YES NO

Financial Responsibility: I understand that if test cancellations are received prior to test set-up, processing will be honored at no charge. I understand that when requests for test cancellation are received after set-up, a cancellation report will be generated and a set-up fee will be charged. Once testing is initiated cancellation is not possible. I understand that I am responsible for all charges for testing and will be contacted for payment in the event my health plan does not reimburse for the test or Ambry Genetics does not receive a response from my health plan in a reasonable length of time.

I have read or have had read to me all of the above statements and understand the information regarding molecular genetics testing and have had the opportunity to ask questions I might have about the testing, the procedure, the risks, and the alternatives prior to my informed consent. I agree to have the molecular genetic testing.

Patient Signature: _____ **Date:** _____

Patient Name (please print): _____