Neurology Test Requisition Form - Page 1 of 2

COMPLETE ENTIRE FORM TO AVOID DELAYS

Ambry Genetics
Aliso Viejo, CA 92656 USA | Toll Free: 866.262.7943 | Fax: 949.900.5501 | ambrygen.com

PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Date of Death (If applicable)	Phone Number/Email
Address City State Zip	Biological Sex ☐F ☐M	Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ☐Other:	

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

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

Collection Date	Specimen ID	Medical Record #

**Blood or saliva from patients with active/recent hematological disease will undergo additional review and may not be accepted in some cases. For these, cultured fibroblasts or fresh/fresh frozen normal tissue are preferred. See ambrygen.com/specimen-requirements for details.*

Phlebotomy Services Request: ☐Phlebotomy draw ☐Insurance preverification first ☐Send 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):

PATIENT HISTORY ☐ No personal history of neurological disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date: Upcoming procedure date:

Reasons for Testing

Birth and Neonatal History ☐N/A
Gestational age at birth: _____ Birth weight: _____
Head circumference at birth (if available):_____

Developmental History ☐N/A
Developmental delay: ☐yes ☐no ☐unknown
Type of delay (choose all that apply): ☐motor ☐language ☐global
Intellectual disability: ☐yes ☐no ☐unknown
Regression or plateau: ☐yes ☐no ☐unknown
Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder? ☐yes ☐no

Seizure History ☐N/A Age at first unprovoked seizure: _____
Has this patient been diagnosed with an epilepsy syndrome? ☐yes ☐no ☐unknown
If yes, please specify: _____

Other History ☐N/A
Hypo-/hyperpigmentation: ☐yes ☐no Telangiectasias: ☐yes ☐no
Other skin abnormality, type: _____
Brain tumor, type: _____ Nerve tumor, type: _____
Other tumor, type: _____

Other Features (choose all that apply)

☐Ataxia	☐Macrocephaly	☐Psychiatric disorder
☐Dysmorphic features	☐Microcephaly	☐Spasticity
☐Hearing disorder	☐Migraine	☐Vision disorder
☐Hypotonia	☐Movement disorder	

Prior Testing

FAMILY HISTORY (Completion of this section is required for orders including parental samples)

Mother - Name:_____ DOB:_____
☐unaffected ☐affected, list symptoms/dx:_____ Dx age:_____
Father - Name:_____ DOB:_____
☐unaffected ☐affected, list symptoms/dx:_____ Dx age:_____
Relationship to patient:_____ ☐Maternal ☐Paternal
Diagnosis:_____ Dx age:_____

ORDERING PHYSICIAN/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

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

CONFIRMATION OF INFORMED CONSENT 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. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity (unless this box is checked ☐).

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 #

Ambry Genetics preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed (*Nothing checked defaults to >$100*):
☐ $100 ☐ Any amount ☐ Other $
☐ Hold order pending patient contact and approval of payment terms regarding out-of-pocket.
Patient preferred method of contact regarding out-of-pocket amount: ☐ Email ☐ Phone

☐ 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 E.P.I.C. 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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Please check the box next to the test(s) being ordered below.
All tests include gene sequence and deletion/duplication analyses unless otherwise indicated.
If this TRF is sent to Ambry without or ahead of the sample, it will be treated as a preverification. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample.

REQUIRED ORDERING CHECKLIST

- ☐ Clinic notes (with pedigree if available)
- ☐ ICD-10 code(s)
- ☐ Clinician & patient signatures
- ☐ Insurer-specific forms (i.e. ABN), if applicable
- ☐ Front/back copy of insurance card(s)

For multiple test orders, testing will be run concurrently (multiple tests initiated at the same time) unless otherwise specified. To order reflexive testing (second test starts pending first test outcome), please clearly indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported out to the clinician, and the requested second test will be canceled; all other findings will automatically reflex (including VUS).

Check to order	Test Name	Test Code	Description
Epilepsy			
☐	EpiRapid **blood only, no saliva**	7033	16 epilepsy genes with treatment associations
☐	EpiRapid reflex to EpilepsyNext **blood only, no saliva**	7034	16 epilepsy genes with treatment associations, reflex to 100 genes for epilepsy

Please complete the following for any EpiRapid test order:

Phone number for verbal results: _____

Name of provider to receive results: _____

Secure email: _____

If there is no answer at the above number, we will send an email to the address provided above. Please send an email prior to shipment including FedEx tracking number to receiving@ambrygen.com.

☐	CustomNext-*Epilepsy*	9530	Up to 100 gene custom epilepsy test^ ☐ Check if parental samples are included
☐	EpiFirst-*Fever*	7011	13 genes for febrile seizures ☐ Check if parental samples are included
☐	EpiFirst-*Fever* reflex to EpilepsyNext	7012	13 genes for febrile seizures, reflex to 100 genes for epilepsy ☐ Check if parental samples are included
☐	EpiFirst-*Focal*	7017	11 genes for non-lesional focal epilepsy ☐ Check if parental samples are included
☐	EpiFirst-*Focal* reflex to EpilepsyNext	7018	11 genes for non-lesional focal epilepsy, reflex to 100 genes for epilepsy ☐ Check if parental samples are included
☐	EpiFirst-*IS*	7013	17 genes for infantile spasms ☐ Check if parental samples are included
☐	EpiFirst-*IS* reflex to EpilepsyNext	7014	17 genes for infantile spasms, reflex to 100 genes for epilepsy ☐ Check if parental samples are included
☐	EpiFirst-*Neonate*	7015	10 genes for neonatal seizures ☐ Check if parental samples are included
☐	EpiFirst-*Neonate* reflex to EpilepsyNext	7016	10 genes for neonatal seizures, reflex to 100 genes for epilepsy ☐ Check if parental samples are included
☐	EpilepsyNext	7019	100 genes for epilepsy ☐ Check if parental samples are included
☐	PMEFirst	7020	*CSTB, EPM2A, NHLRC1* ☐ Check if parental samples are included
☐	PMENext	7022	21 genes for PME ☐ Check if parental samples are included
☐	PMEFirst reflex to PMENext	7021	*CSTB, EPM2A, NHLRC1*, reflex to 21 genes for PME ☐ Check if parental samples are included
☐	*CSTB* repeat expansion	7084	*CSTB* repeat expansion analysis
☐	Neurodevelopment-*Expanded*	7028	196 genes for epilepsy, ID, ASDs ☐ Check if parental samples are included
Hereditary Neuropathy			
☐	Familial transthyretin amyloidosis	1560	*TTR*
Leukodystrophy			
☐	Canavan disease	1226	*ASPA*
☐	Pelizaeus-Merzbacher disease	4180	*PLP1*
☐	X-linked adrenoleukodystrophy	3760	*ABCD1*
Lysosomal Storage Disorders			
☐	NCLNext	7025	13 genes for NCL /Batten disease ☐ Check if parental samples are included
☐	Gaucher disease	1820	*GBA*
☐	Hunter disease	1940	*IDS*
☐	Niemann-Pick disease, type C	8740	*NPC1, NPC2*
☐	Tay-Sachs disease	1240	*HEXA*

Check to order	Test Name	Test Code	Description
Clinical Genomics			
☐	Karyotype	3660	Green-top sodium-heparin tube
☐	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
☐	Follow-up parental FISH studies – **ONLY following SNP Array (5490) at Ambry**	3750	Green-top sodium heparin tube, submit proband sample for positive control. Name of proband tested at Ambry: _____
☐	ExomeNext	9999	☐ Opt-out of analysis and reporting of Novel Genetic Etiologies
Order through AP2*	ExomeNext-*Select*	9500	Up to 500 gene custom exome sequencing test

**AP2 is AmbryPort 2.0, our online portal ambrygen.com/ap2*

If ordering ExomeNext/ExomeNext-Rapid, please complete:
Secondary Findings Report: Check below to order the ACMG Recommended List of secondary findings. If neither box is checked secondary findings will not be reported. Secondary findings results are issued in a separate report. (For expanded secondary findings options and pricing please complete the "ExomeNext Expanded Secondary Findings Request Form" and submit with sample).
☐ Yes: I choose to receive the ACMG Recommended List of secondary findings
☐ No: I choose to decline the ACMG Recommended List of secondary findings

Migraine			
☐	Familial hemiplegic migraine	7035	*ATP1A2, CACNA1A, PRRT2, SCN1A* ☐ Check if parental samples are included
Neurocutaneous/Neuro-Oncology Disorders			
☐	Ataxia-telangiectasia	9014	*ATM*
☐	BrainTumorNext	8847	27 genes for brain tumors
☐	HHTFirst	8673	*ACVRL1, ENG, SMAD4*
☐	HHTNext	8672	*ACVRL1, ENG, SMAD4, GDF2, RASA1*
☐	HHTFirst reflex to HHTNext	8671	*ACVRL1, ENG, SMAD4* reflex to *GDF2, RASA1*
☐	Legius syndrome	5724	*SPRED1*
☐	Li-Fraumeni syndrome	2866	*TP53*
☐	Neurofibromatosis 1	5704	*NF1*
☐	Neurofibromatosis 2	9024	*NF2*
☐	NF1 reflex to Legius	5730	*NF1* reflex to *SPRED1*
☐	Nevoid basal cell carcinoma syndrome/ Gorlin syndrome	5684	*PTCH1*
		9050	*SUFU*
☐	Schwannomatosis	7180	*SMARCB1*
☐	Tuberous sclerosis	5904	*TSC1, TSC2*
☐	von Hippel-Lindau	2606	*VHL*
Neurodevelopmental Disorders			
☐	Angelman syndrome	7029	Methylation studies of 15q11-13, reflex to *UBE3A*
☐	Angelman/Prader-Willi methylation studies	2440	Methylation studies of 15q11-13
☐	Rett/AngelmanNext	7026	22 genes for Rett, Angelman, related syndromes ☐ Check if parental samples are included
☐	Rett syndrome	2026	*MECP2*
☐	AutismFirst	7023	16 genes for syndromic ASDs ☐ Check if parental samples are included
☐	AutismNext	7024	48 genes for syndromic and non-syndromic ASDs ☐ Check if parental samples are included
☐	Autism, macrocephaly	2106	*PTEN*
☐	Fragile X syndrome	4544	*FMR1* repeat expansion analysis and methylation studies
☐	IDNext	7027	140 genes for syndromic and non-syndromic ID ☐ Check if parental samples are included
☐	Neurodevelopment-*Expanded*	7028	196 genes for ID, ASDs, and epilepsy ☐ Check if parental samples are included

SINGLE SITE ANALYSIS (Please include a copy of relative's report)

Gene(s): _____ Mutation(s): _____

Relative Name: _____

Relationship to Relative: _____ Accession # (If tested at Ambry): _____

Positive control sample: ☐ will be provided ☐ already at Ambry ☐ not available

^ *Required: completed CustomNext-Epilepsy supplemental form. ambrygen.com/forms*