Pulmonology 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 pulmonology disease

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

Reasons for Testing

☐ Positive newborn screen

☐ Infections: _____

☐ Sweat chloride: _____mmol/L
☐ Sweat chloride: ☐<40 ☐ 40-60 ☐ >60
☐ CBAVD
☐ Meconium ileus
☐ Pancreatic insufficiency IRT level: _____

☐ Respiratory distress, explain: _____

☐ Respiratory assistance devices: _____

☐ Ultrasound findings: _____

☐ Other: _____

Relevant lab results (include copies if possible)

FAMILY HISTORY

☐ None (maternal) ☐ Maternal hx unknown ☐ None (paternal) ☐ Paternal hx unknown

Relationship to patient_____ ☐ Maternal ☐ Paternal

Diagnosis_____ 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:

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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)

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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.

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
Alpha-1 Antitrypsin Deficiency			
☐	Alpha-1 antitrypsin deficiency	1140	*SERPINA1*
Congenital Central Hypoventilation Syndrome			
☐	Congenital central hypoventilation syndrome	1580	*PHOX2B* gene sequence
Cystic Fibrosis			
☐	508 ONLY	1008	Test for *CFTR* deltaF508 mutation only
☐	508 FIRST	1002	Test for *CFTR* deltaF508 mutation with reflex to *CFTR* gene sequence and deletion/duplication
☐	CF 102	1018	Screening panel of 102 *CFTR* disease-causing mutations
☐	*CFTR* gene sequence with reflex to deletion/ duplication analysis	1006	☐ Report poly T/TG status
☐	*CFTR* gene sequence and deletion/duplication analysis	1007	☐ Report poly T/TG status
☐	*CFTR* gene sequence	1000	*CFTR* gene sequence
☐	*CFTR* deletion/ duplication analysis	1004	*CFTR* deletion/duplication analysis
☐	Poly T/TG repeat analysis	1010	Poly T repeat analysis with reflex to TG repeat analysis
☐	*CFTR* SSA	1008	*CFTR* Single Site Analysis Mutation: _____

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

Check to order	Test Name	Test Code	Description
Primary Ciliary Dyskinesia			
☐	PCDNext	8122	21 genes for primary ciliary dyskinesia
Pulmonary Fibrosis			
☐	Telomere-related pulmonary fibrosis	8140	*TERT, TERC*
Respiratory Distress Syndrome			
☐	Surfactant dysfunction panel	8100	*ABCA3, SFTPB, SFTPC* gene sequence
☐	*ABCA3*-related surfactant dysfunction	1300	*ABCA3* gene sequence
☐	Surfactant protein B deficiency	1160	*SFTPB* gene sequence
☐	Surfactant protein C deficiency	1180	*SFTPC* gene sequence
Clinical Genomics			
☐	Karyotype	3660	Chromosome analysis (requires sodium-heparin tube)
☐	Karyotype, rule out mosaic	3662	Chromosome analysis (requires 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 available following SNP Array (5490) completed at Ambry**	3750	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
☐	ExomeNext-*Rapid*	9999R	☐ Opt-out of analysis and reporting of Novel Genetic Etiologies
Must be ordered 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