

COMPLETE ENTIRE FORM TO AVOID DELAYS

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 <input type="checkbox"/> F <input type="checkbox"/> M	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"/> Portuguese <input type="checkbox"/> Other:		

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

Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Other:				<input type="checkbox"/> 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.

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 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:
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INSURANCE BILLING (Include copy of both sides of insurance card) **INSTITUTIONAL BILLING**

Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name and DOB of Policy Holder (if not self)	Facility Name <input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #	HMO Auth #
Amby 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): <input type="checkbox"/> \$100 <input type="checkbox"/> Any amount <input type="checkbox"/> Other \$ <input type="checkbox"/> Hold order pending patient contact and approval of payment terms regarding out-of-pocket. Patient preferred method of contact regarding out-of-pocket amount: <input type="checkbox"/> Email <input type="checkbox"/> Phone		Address Contact Name Phone Number E-mail/Fax
		<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> 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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Cancer Test Requisition Form - Page 2 of 4

INDICATIONS FOR TESTING (Check all that apply)

ICD-10 code(s): _____

 Test results will affect immediate medical management, date results needed (if known): _____

PATIENT CLINICAL HISTORY
 No personal history of cancer

Cancer/Tumor	Age at Dx	Pathology and Other Info	
Brain tumor			
Breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
2nd primary breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
Colorectal		Location: _____	
Melanoma			
Ovarian		<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal	
Pancreatic			
Prostate		Gleason Score: _____	Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N
Uterine			
Hematologic		Type: <input type="checkbox"/> Allogenic bone marrow or peripheral stem cell transplant*	
Other Cancer		Type: _____	
GI polyps		<input type="checkbox"/> Adenomatous Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+	<input type="checkbox"/> Other type: _____ Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+

Other clinical history: _____

**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.*

PATIENT TESTING HISTORY (Please include copies of any previous test results)
 No previous molecular and/or genetic testing

 Germline genetic testing Test(s) performed: _____
 Result (s): _____
 Somatic test/tumor profile Test(s) performed: _____
 Result(s): _____

 Microsatellite instability analysis:
 Stable (MSS) Unstable/high (MSI-H) Unstable/low (MSI-L)
 IHC, if multiple primaries, tumor used: _____
 Proteins present: _____ Proteins absent: _____

FAMILY HISTORY*

**Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.*

 None (maternal) None (paternal) Maternal history unknown Paternal history unknown

Relation to patient	Maternal	Paternal	Cancer/Polyp Type	Dx age	Relation to patient	Maternal	Paternal	Cancer/Polyp Type	Dx age
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		

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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 preverified. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample.

INSURANCE ORDERING CHECKLIST	
<input type="checkbox"/>	Clinic notes (with pedigree if available)
<input type="checkbox"/>	ICD-10 code(s)
<input type="checkbox"/>	Clinician & patient signatures
<input type="checkbox"/>	Insurer-specific forms (i.e. ABN), if applicable
<input type="checkbox"/>	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).

MULTI-GENE ORDERS

For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history:

- Adenomatous polyposis (APC/MUTYH)
- Hereditary breast and ovarian cancer (BRCA1/2)
- Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM)
- Testing is clinically indicated for other gene(s):
- None of the above

To complete your multi-gene order, please select a test option to the right. (See supplemental information on page 4 for details).

¹ If you selected BRCA1/2, one of these multi-gene reports may be requested.

² If you selected Lynch, one of these multi-gene reports may be requested.

³ If you selected APC and MUTYH, one of these multi-gene reports may be requested.

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

<input type="checkbox"/>	BrainTumorNext	8847	27 gene brain tumor test ²
<input type="checkbox"/>	BRCAPlus	8836	6 gene breast cancer test ¹
<input type="checkbox"/>	BRCAPlus-Expanded	8837	8 gene breast cancer test ¹
<input type="checkbox"/>	BreastNext	8820	17 gene breast cancer test ¹
<input type="checkbox"/>	CancerNext	8824	34 gene cancer test ^{1,2,3}
<input type="checkbox"/>	CancerNext-Expanded	8874	67 gene cancer test ^{1,2,3}
<input type="checkbox"/>	ColoNext	8822	17 gene colorectal cancer test ^{2,3}
<input type="checkbox"/>	CustomNext-Cancer	9510	up to 67 gene custom test*
<input type="checkbox"/>	GYNplus	8835	13 gene ovarian/uterine cancer test ^{1,2}
<input type="checkbox"/>	MelanomaNext	8849	8 gene melanoma test ¹
<input type="checkbox"/>	OvaNext	8830	25 gene ovarian/breast/uterine cancer test ^{1,2}
<input type="checkbox"/>	PancNext	8042	13 gene pancreatic cancer test ^{1,2}
<input type="checkbox"/>	Pancreatitis panel	8022	4 gene pancreatitis test
<input type="checkbox"/>	PGLNext	5504	12 gene PGL/PCC test
<input type="checkbox"/>	ProstateNext	8845	14 gene prostate cancer test ^{1,2}
<input type="checkbox"/>	RenalNext	5900	19 gene renal cancer test ²

SINGLE SYNDROME ORDERS

Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
Hereditary Brain Tumors				Gastrointestinal Cancer^^ (Cont.)			
<input type="checkbox"/>	AIP	9018	Familial isolated pituitary adenomas	<input type="checkbox"/>	PMS2	4646	Lynch syndrome
<input type="checkbox"/>	CDKN1B	9022	Multiple endocrine neoplasia type 4	<input type="checkbox"/>	POLD1 and POLE gene sequence	8877	Polymerase proofreading-associated polyposis
<input type="checkbox"/>	NF2	9024	Neurofibromatosis type 2	<input type="checkbox"/>	STK11	2766	Peutz-Jeghers syndrome
<input type="checkbox"/>	POT1	9032		Genitourinary Cancer			
<input type="checkbox"/>	PRKARIA	9038	Carney Complex	<input type="checkbox"/>	BAP1	9044	
<input type="checkbox"/>	SMARCB1	7180	Rhabdoid tumor predisposition/schwannomatosis	<input type="checkbox"/>	FH	6301	Hereditary leiomyomatosis and renal cell cancer
<input type="checkbox"/>	SUFU	9050	Gorlin syndrome	<input type="checkbox"/>	FLCN	5921	Birt-Hogg-Dubé syndrome
Hereditary Breast and/or Ovarian Cancer				<input type="checkbox"/>	VHL	2606	Von-Hippel Lindau disease
<input type="checkbox"/>	ATM	9014	Ataxia-telangiectasia	<input type="checkbox"/>	TSC1 and TSC2	5904	Tuberous sclerosis complex
<input type="checkbox"/>	BRCA1/2	8838	Hereditary breast and ovarian cancer	Endocrine Tumors			
<input type="checkbox"/>	BRCA1/2 del/dup only	5890		<input type="checkbox"/>	MAX	9062	Hereditary PGL/PCC
<input type="checkbox"/>	BRCA1/2 Ashkenazi Jewish 3-site mutation panel	5892		<input type="checkbox"/>	MEN1	2646	Multiple endocrine neoplasia type 1
<input type="checkbox"/>	BRCA1/2 Ashkenazi Jewish 3-site mutation panel with reflex to BRCA1/2 analysis if negative	5894		<input type="checkbox"/>	RET gene sequence	2680	Multiple endocrine neoplasia type 2
<input type="checkbox"/>	CHEK2	9016	PTEN-related disorders (including Cowden syndrome)	<input type="checkbox"/>	SDHA	9052	Hereditary PGL/PCC
<input type="checkbox"/>	DICER1	5260		<input type="checkbox"/>	SDHAF2	9060	Hereditary PGL/PCC
<input type="checkbox"/>	PALB2	2366	Rhabdoid tumor predisposition syndrome type 2	<input type="checkbox"/>	SDHB	9054	Hereditary PGL/PCC
<input type="checkbox"/>	PTEN	2106		<input type="checkbox"/>	SDHC	9056	Hereditary PGL/PCC
<input type="checkbox"/>	SMARCA4	9028		<input type="checkbox"/>	SDHD	9058	Hereditary PGL/PCC
<input type="checkbox"/>	TP53	2866	Li-Fraumeni syndrome	<input type="checkbox"/>	TMEM127	9066	Hereditary PGL/PCC
Gastrointestinal Cancer^^				Skin Cancer/Melanoma			
<input type="checkbox"/>	APC	3040	Familial adenomatous polyposis	<input type="checkbox"/>	CDKN2A and CDK4 concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
<input type="checkbox"/>	APC and MUTYH	8726	Adenomatous polyposis	<input type="checkbox"/>	PTCH1	5684	Gorlin syndrome
<input type="checkbox"/>	BMPR1A and SMAD4	8604	Juvenile polyposis syndrome	Other Hereditary Cancer Testing			
<input type="checkbox"/>	CDH1	4726	Hereditary diffuse gastric cancer	<input type="checkbox"/>	NF1	5704	Neurofibromatosis type 1
<input type="checkbox"/>	EPCAM del/dup	8519	Lynch syndrome	<input type="checkbox"/>	RBI	5426	Hereditary retinoblastoma
<input type="checkbox"/>	GREM1 duplication	8878	Mixed polyposis syndrome	Other Single Syndrome Orders			
<input type="checkbox"/>	Lynch syndrome	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup	<input type="checkbox"/>	Please visit ambrygen.com/hereditary-cancer-single-gene-tests for details.		
<input type="checkbox"/>	Lynch syndrome (sequential)	8515	Step 1: MLH1, MSH2, and MSH6 + EPCAM del/dup; Step 2: PMS2	Test Code(s): _____ Gene/Test Name(s): _____			
<input type="checkbox"/>	MLH1	8508	Lynch syndrome	SINGLE SITE ANALYSIS (Please include a copy of relative's report)			
<input type="checkbox"/>	MSH2 + EPCAM del/dup	8510	Includes MSH2 inversion	Gene(s): _____ Mutation(s): _____			
<input type="checkbox"/>	MSH2 inversion	2226	Lynch syndrome	Relative Name: _____			
<input type="checkbox"/>	MSH6	8512	Lynch syndrome	Relationship to Relative: _____ Accession # (if tested at Ambry): _____			
<input type="checkbox"/>	MUTYH	4661	MUTYH-associated polyposis	Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available			

^^If patient has Medicare and only Lynch is being ordered, please order 8515

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Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	APC, MUTYH
BrainTumorNext (27 genes)	8847	AIP, ALK, APC, CDKN1B, CDKN2A, DICER1, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, POT1, PRKAR1A, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
BRCAPlus (6 genes)	8836	BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53
BRCAPlus-Expanded (8 genes)	8837	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53
BreastNext (17 genes)	8820	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MRE11A, MUTYH, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, TP53
CancerNext (34 genes)	8824	APC, ATM, BARD1, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1, HOXB13, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, POLD1, POLE, PTEN, RAD50, RAD51C, RAD51D, SMAD4, SMARCA4, STK11, TP53
CancerNext-Expanded (67 genes)	8874	AIP, ALK, APC, ATM, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, DICER1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MIF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEIM127, TP53, TSC1, TSC2, VHL, XRCC2
ColoNext (17 genes)	8822	APC, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
CustomNext-Cancer (up to 67 genes) Required: complete CustomNext-Cancer supplemental form. ambrygen.com/forms	9510	AIP, ALK, APC, ATM, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, DICER1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MIF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEIM127, TP53, TSC1, TSC2, VHL, XRCC2
GYNplus (13 genes)	8835	BRCA1, BRCA2, BRIP1, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53
HBOC	8838	BRCA1, BRCA2
Lynch syndrome/HNPCC	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup
MelanomaNext (8 genes)	8849	BAP1, BRCA2, CDK4, CDKN2A, MIF, PTEN, RB1, TP53
OvaNext (25 genes)	8830	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMARCA4, STK11, TP53
PancNext (13 genes)	8042	APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
Pancreatitis panel (4 genes)	8022	CFTR, PRSS1, SPINK1, CTRC
PGLNext (12 genes)	5504	FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEIM127, VHL
ProstateNext (14 genes)	8845	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53
RenalNext (19 genes)	5900	BAP1, EPCAM, FH, FLCN, MET, MIF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL

Updated Ordering Process (as of June 8, 2016)

We have improved the ordering and reporting process for our hereditary cancer panels. This helps confirm that testing for one or more of the following genes is clinically indicated: APC, BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, MUTYH, and PMS2.

If you are ordering a multi-gene test, please first select a clinically indicated condition and complete your order by selecting a multi-gene order.

Please indicate if your patient meets clinical and/or insurance testing criteria, or if the testing is otherwise clinically indicated for one or more of the following conditions:

- Adenomatous polyposis (APC/MUTYH)
- Hereditary breast and ovarian cancer (BRCA1/2)
- Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM)

If testing is not clinically indicated for your patient for any of the listed options, please either fill in the other gene(s) option or select "none of the above".

To complete your multi-gene order, please select one of the appropriate test options and/or select "other" and enter an appropriate test code(s)/test name(s).

For single gene orders, please select the appropriate test option or enter the gene(s) and/or test name(s), as well as the relevant test code in the single gene orders section.

For additional details about our single gene testing options, please visit ambrygen.com/hereditary-cancer-single-gene-tests.

Example: For a ColoNext multi-gene order, when Lynch testing is clinically indicated for the patient

MULTI-GENE ORDERS				
For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history: <input type="checkbox"/> Adenomatous polyposis (APC/MUTYH) <input type="checkbox"/> Hereditary breast and ovarian cancer (BRCA1/2) <input checked="" type="checkbox"/> Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM) <input type="checkbox"/> Testing is clinically indicated for other gene(s): <input type="checkbox"/> None of the above To complete your multi-gene order, please select a test option to the right. (See supplemental information on page 4 for details). ¹ If you selected BRCA1/2, one of these multi-gene reports may be requested. ² If you selected Lynch, one of these multi-gene reports may be requested. ³ If you selected APC and MUTYH, one of these multi-gene reports may be requested. *Required: completed CustomNext-Cancer supplemental form. ambrygen.com/forms	<input type="checkbox"/>	BrainTumorNext	8847	27 gene brain tumor test ²
	<input type="checkbox"/>	BRCAPlus	8836	6 gene breast cancer test ¹
	<input type="checkbox"/>	BRCAPlus-Expanded	8837	8 gene breast cancer test ¹
	<input type="checkbox"/>	BreastNext	8820	17 gene breast cancer test ¹
	<input type="checkbox"/>	CancerNext	8824	34 gene cancer test ^{1,2,3}
	<input type="checkbox"/>	CancerNext-Expanded	8874	67 gene cancer test ^{1,2,3}
	<input checked="" type="checkbox"/>	ColoNext	8822	17 gene colorectal cancer test ^{2,3}
	<input type="checkbox"/>	CustomNext-Cancer	9510	up to 67 gene custom test*
	<input type="checkbox"/>	GYNplus	8835	13 gene ovarian/uterine cancer test ^{1,2}
	<input type="checkbox"/>	MelanomaNext	8849	8 gene melanoma test ¹
	<input type="checkbox"/>	OvaNext	8830	25 gene ovarian/breast/uterine cancer test ^{1,2}
	<input type="checkbox"/>	PancNext	8042	13 gene pancreatic cancer test ^{1,2}
	<input type="checkbox"/>	Pancreatitis panel	8022	4 gene pancreatitis test
	<input type="checkbox"/>	PGLNext	5504	12 gene PGL/PCC test
	<input type="checkbox"/>	ProstateNext	8845	14 gene prostate cancer test ^{1,2}
<input type="checkbox"/>	RenalNext	5900	19 gene renal cancer test ²	