

COMPLETE ENTIRE FORM TO AVOID DELAYS

PATIENT INFORMATION			FAMILY HISTORY			
Name (Last, First, MI)			<input type="checkbox"/> None (maternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> None (paternal) <input type="checkbox"/> Paternal hx unknown			
DOB (MM/DD/YY)	Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Phone Number/Email	Relation to patient	Mat.	Pat.	Dx age
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"/> Portuguese <input type="checkbox"/> Other:						
PATIENT HISTORY (Supply clinic notes and pedigree when possible)			SPECIMEN INFORMATION * (For phlebotomy service select all services you are requesting)			
PERSONAL HISTORY OF CANCER: <input type="checkbox"/> No personal history of cancer Type(s): Age(s) at Dx: Treatment decision/Surgery date: Breast pathology: 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 Other pathology: Other clinical history:			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	MRN	*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 ambraygen.com/specimen-requirements for details.
			Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send kit to patient <i>*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.</i>			
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 Name (Last, First) (Code)			Phone/Fax/Email	Medical Professional 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 <input type="checkbox"/>).						
<i>Signature Required for Processing</i> Medical Professional Signature:					Date:	
INDICATIONS FOR TESTING (Check all that apply)						
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Family history <input type="checkbox"/> Positive or normal control <input type="checkbox"/> Other				ICD-10 code(s):		
TEST REQUESTED - GYN CANCER TEST OPTIONS						
If this TRF is sent to Ambray 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. <i>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).</i>						
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"/> Hereditary breast and ovarian cancer (BRCA1/2) <input 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 below (see supplemental pages for details): <input type="checkbox"/> GYNplus (8835) <input type="checkbox"/> CancerNext (8824) <input type="checkbox"/> OvaNext (8830) <input type="checkbox"/> Other Test Code: _____ Test Name: _____				Single Syndrome Orders Single gene analysis is available for listed panels. Visit ambraygen.com/hereditary-cancer-single-gene-tests for details. <input type="checkbox"/> BRCA1/2 Gene sequencing and del/dup (8838) <input type="checkbox"/> Lynch syndrome (8517) ^ Test Code(s): Gene/Test Name(s): *If patient has Medicare and only Lynch is being ordered, please order 8515.		
				Single Site Analysis (SSA) (Include relative report) Gene(s): _____ Mutation(s): _____ Previously Tested Relative (name): _____ Relationship to Relative: _____ Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambray <input type="checkbox"/> not available		
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 #	Address		
Ambray 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 \$				Contact Name		E-mail/Fax
<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				<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable to Ambray 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 Ambray Genetics Corporation (Ambray), authorize Ambray 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 Ambray money received from my health insurance company.						
For patient payment by credit card: I hereby authorize Ambray Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambray'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 Ambray 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:						
<input type="checkbox"/> I am a New York resident and I give Ambray Genetics permission to store my sample for longer than 60 days. NOTE: If left blank, consent is interpreted as "NO".						
<i>Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:</i>					Date:	

REQUIRED INSURANCE ORDERING CHECKLIST

- Clinic Notes (Pedigree if available)
- ICD-10 Code(s)
- Clinician & Patient Signatures
- Insurer Specific Forms (i.e. ABN)
- Copy of Insurance Cards

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, PRKARIA, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
BRCPlus (6 genes)	8836	BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53
BRCPlus-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, MITF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKARIA, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, 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, MITF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKARIA, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, 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, MITF, 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
ProstateNext (14 genes)	8845	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53
PGLNext (12 genes)	5504	FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
RenalNext (19 genes)	5900	BAP1, EPCAM, FH, FLCN, MET, MITF, 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: *BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, 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:

- 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 GYNplus multi-gene order, when *BRCA1/2* 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:

- 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 below (see supplemental pages for details):

- GYNplus (8835) CancerNext (8824)
- OvaNext (8830) Other Test Code: _____ Test Name: _____

For single gene genetic testing of *PTEN*:

Single Syndrome Orders

Single gene analysis is available for listed panels. Visit ambrygen.com/hereditary-cancer-single-gene-tests for details.

- BRCA1/2* Gene sequencing and del/dup (8838) Lynch syndrome (8517)

Test Code(s): **2106** Gene/Test Name(s): **PTEN**

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

Single Site Analysis (SSA) (Include relative report)

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

Previously Tested Relative (name): _____

Relationship to Relative: _____

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