Clinical Genomics Family Member Test Requisition Form - Page 1 of 1
(Exome Sequencing)

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COMPLETE ENTIRE FORM TO AVOID DELAYS

FAMILY MEMBER 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 (Not accepted for ExomeNext and ExomeNext-*Rapid* probands)
☐DNA, Source: ☐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.

CLINICAL INFORMATION

Is Family Member affected with the same phenotype as the proband? ☐Yes ☐No ☐Partially ☐Possibly

TEST MENU

☐9999 Family member for ExomeNext (no charge)
☐9500 Family member for ExomeNext-*Select* (no charge)
☐9999R Family member for ExomeNext-*Rapid* (no charge)
☐9999P Family member for ExomeNext-*Prenatal* (no charge)
☐Other _____(Test Code/Test Name)

Proband Name: _____
Relationship to proband: _____

SECONDARY FINDINGS

Secondary findings results are available for each family member chosen to be sequenced as part of the trio. The family members chosen as the ExomeNext trio are at the discretion of the laboratory. Thus, not all consented family members may receive Secondary Findings reports. Please note, pathogenic mutations that may be present in a family member but not in the proband may be detected and reported.

Please choose the appropriate option below. If neither box is checked, secondary findings will not be reported for the family member listed above. Secondary findings are not available with ExomeNext-Select orders. (For expanded secondary findings options and pricing please complete the "ExomeNext Expanded Secondary Findings Request Form" and submit along 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.

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

ADDITIONAL RESULTS RECIPIENTS

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:

Family Member Acknowledgement: I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the whole-exome sequencing process prior to testing, and I would like to proceed with test processing.

I understand that the primary exome testing is being performed in order to assist analysis for my family member (proband), that a primary report will only be generated for the proband, and that it may be possible to infer information about my results based on the proband's report.

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".

If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.

Family Member/Guardian Signature:_____ Date:_____

For all exome orders, Ambry includes testing for co-segregation analysis (aka: family testing for candidate alterations) if samples are sent before testing begins.