

Specific Site Analysis Test Requisition Form - Page 1 of 2

(Known Familial Alteration Analysis)



Aliso Viejo, CA 92656 USA

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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"/> Cord Blood** <input type="checkbox"/> DNA, Source:			<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. **If submitting Cord blood, please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.						
Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> 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):						
PRENATAL SAMPLES ONLY						
Sample type: <input type="checkbox"/> Direct CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured amnio <input type="checkbox"/> POC <input type="checkbox"/> Cultured POC					Gestational age at sample collection	
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, PRE-TEST GENETIC COUNSELING, 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. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third party service, Informed DNA (unless otherwise noted), as required by the patient's insurance provider (unless this box is checked <input type="checkbox"/>). Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.						
Signature Required for Processing Medical Professional Signature:					Date:	
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		
Out Of Pocket: Ambry Genetics will start testing immediately. We will attempt to contact the patient if: <input type="checkbox"/> Out-of-pocket amount is greater than \$100 (default) <input type="checkbox"/> There is any out-of-pocket amount <input type="checkbox"/> Do not initiate testing until patient is contacted and approves payment terms regarding out-of-pocket Patient agrees to contact regarding out-of-pocket amount by: <input type="checkbox"/> Email <input type="checkbox"/> Phone (includes texts) - confirm mobile # _____				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:						
<input type="checkbox"/> 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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SPECIFIC SITE ANALYSIS (5555)		
Positive control: <input type="checkbox"/> Sent <input type="checkbox"/> To be sent <input type="checkbox"/> Not available <input type="checkbox"/> Available at Ambry, accession #:		
<p>The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory:</p> <ol style="list-style-type: none"> 1. Proband report (mandatory) 2. Positive control (recommended; required for prenatal testing) <p>ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence alteration. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.</p>	ALTERATION TO BE TESTED	
	Gene 1	Alteration 1
	Gene 2	Alteration 2
	Gene 3	Alteration 3
	Gene 4	Alteration 4
PATIENT CLINICAL INFORMATION		
<input type="checkbox"/> Healthy <input type="checkbox"/> Affected/Symptomatic, age at diagnosis: _____ Please list relevant clinical findings with ICD-10 codes: _____		
PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)		
Previously Detected Alteration(s)	Gene Name	Testing Lab
Patient previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name	Date of Birth (MM/DD/YY)	Relation
FOR PRENATAL SPECIMENS ONLY: MATERNAL CELL CONTAMINATION (Required for fetal specimens)		
<input type="checkbox"/> 1260 MCC for amniotic fluid culture or CVS (run concurrently with test) <input type="checkbox"/> 1262 MCC Reference for maternal blood sample (No Charge)		