

**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"/> Cord Blood** <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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> 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):					
PATIENT HISTORY <input type="checkbox"/> No personal history of pulmonology disease					
PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date:			Upcoming procedure date:		
<b>Reasons for Testing</b>					
<input type="checkbox"/> Positive newborn screen  <input type="checkbox"/> Infections: _____ <input type="checkbox"/> Sweat chloride: _____mmol/L <input type="checkbox"/> Sweat chloride: <input type="checkbox"/> <40 <input type="checkbox"/> 40-60 <input type="checkbox"/> >60 <input type="checkbox"/> CBAVD <input type="checkbox"/> Meconium ileus <input type="checkbox"/> Pancreatic insufficiency IRT level: _____  <input type="checkbox"/> Respiratory distress, explain: _____  <input type="checkbox"/> Respiratory assistance devices: _____  <input type="checkbox"/> Ultrasound findings: _____  <input type="checkbox"/> Other: _____			<b>Relevant lab results (include copies if possible)</b>   <div style="background-color: #0070C0; color: white; padding: 2px;"><b>FAMILY HISTORY</b></div> <input type="checkbox"/> None (maternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> None (paternal) <input type="checkbox"/> Paternal hx unknown Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Diagnosis _____ Dx age _____ Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> 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
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 <input type="checkbox"/> ).					
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	
<b>Out Of Pocket:</b> 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  <div style="background-color: #0070C0; color: white; padding: 2px;"><b>PATIENT PAYMENT</b></div> <input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)		
<b>Patient Acknowledgement:</b> 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. <b>For patient payment by credit card:</b> 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.					
<b>FOR NY RESIDENTS:</b> <input type="checkbox"/> I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. <b>NOTE:</b> If left blank, consent is interpreted as "NO".					
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:				Date:	

## Pulmonology Test Requisition Form - Page 2 of 2

**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)

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
<b>Congenital Central Hypoventilation Syndrome</b>			
<input type="checkbox"/>	Congenital central hypoventilation syndrome	1580	<i>PHOX2B</i> gene sequence
<b>Cystic Fibrosis</b>			
<input type="checkbox"/>	508 FIRST	1002	<input type="checkbox"/> Report poly T/TG status Test for <i>CFTR</i> deltaF508 mutation with reflex to <i>CFTR</i> gene sequence and deletion/duplication
<input type="checkbox"/>	<i>CFTR</i> gene sequence and deletion/duplication analysis	1007	<input type="checkbox"/> Report poly T/TG status
<b>SINGLE SITE ANALYSIS (Please include a copy of relative's report)</b>			
Gene(s): _____ Mutation(s): _____			
Relative Name: _____			
Relationship to Relative: _____			
Accession # (If tested at Ambry): _____			
Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available			
<b>FOR PRENATAL SPECIMENS ONLY: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)</b>			
<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)			

Check to order	Test Name	Test Code	Description
<b>Primary Ciliary Dyskinesia</b>			
<input type="checkbox"/>	PCDNext	8122	<input type="checkbox"/> Report poly T/TG status 21 genes for primary ciliary dyskinesia
<b>Pulmonary Fibrosis</b>			
<input type="checkbox"/>	Telomere-related pulmonary fibrosis	8140	<i>TERT, TERC</i>
<b>Respiratory Distress Syndrome</b>			
<input type="checkbox"/>	Surfactant dysfunction panel	8100	<i>ABCA3, SFTPB, SFTPC</i> gene sequence
<b>Clinical Genomics</b>			
<input type="checkbox"/>	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)
<input type="checkbox"/>	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
<input type="checkbox"/>	Parental targeted microarray	5495	Paid option. Only available following SNP Array (5490) completed at Ambry. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambry: _____
<input type="checkbox"/>	ExomeNext- <i>Proband</i>	9993	Proband only exome sequencing Secondary Findings <sup>^^</sup> : <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext- <i>Proband</i> plus mtDNA <sup>^</sup>	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings <sup>^^</sup> : <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext- <i>Trio</i>	9995	Trio exome sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings <sup>^^</sup> : <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext- <i>Trio</i> plus mtDNA <sup>^</sup>	9996	Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings <sup>^^</sup> : <input type="checkbox"/> Opt-out
Order through AP*	ExomeNext- <i>Select</i>	9500	Rapid Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings <sup>^^</sup> : <input type="checkbox"/> Opt-out

<sup>^</sup>Mitochondrial (mtDNA) testing cannot be performed on saliva samples.  
<sup>^^</sup>Secondary Findings: If box is left unchecked, the ACMG recommended list of Secondary Findings will be reported. Secondary Findings are not available for ExomeNext-Select orders.  
 \*AP is AmbryPort, our online portal [ambrygen.com/ap](http://ambrygen.com/ap)

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