Neurology Test Requisition Form - Page 1 of 4

Ambry Genetics
A Konica Minolta Company
Aliso Viejo, CA 92656 USA | Toll Free: 866.262.7943 | Fax: 949.900.5501 | ambrygen.com

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 ☐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 ☐DNA ☐Cord blood** ☐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.*
***If submitting Cord blood, please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.*

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.

INDICATION(S) FOR TESTING

ICD-10 code(s):

PATIENT HISTORY ☐ No personal history of neurological disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date: Upcoming procedure date:

Reasons for Testing

Birth and Neonatal History ☐N/A
Gestational age at birth: _____ Birth weight: _____
Head circumference at birth (if available):_____

Developmental History ☐N/A
Developmental delay: ☐yes ☐no ☐unknown
Type of delay (choose all that apply): ☐motor ☐language ☐global
Intellectual disability: ☐yes ☐no ☐unknown
Regression or plateau: ☐yes ☐no ☐unknown
Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder? ☐yes ☐no

Seizure History ☐N/A Age at first unprovoked seizure: _____
Has this patient been diagnosed with an epilepsy syndrome? ☐yes ☐no ☐unknown
If yes, please specify: _____

Other History ☐N/A
Hypo-/hyperpigmentation: ☐yes ☐no Telangiectasias: ☐yes ☐no
Other skin abnormality, type: _____
Brain tumor, type: _____Nerve tumor, type: _____
Other tumor, type: _____

Other Features (choose all that apply)

☐Ataxia	☐Macrocephaly	☐Psychiatric disorder
☐Dysmorphic features	☐Microcephaly	☐Spasticity
☐Hearing disorder	☐Migraine	☐Vision disorder
☐Hypotonia	☐Movement disorder	

Prior Testing

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 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 ☐). 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)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Auth #

Out Of Pocket:
Ambry Genetics will start testing immediately. We will attempt to contact the patient if:
☐ Out-of-pocket amount is greater than $100 (default) ☐ There is any out-of-pocket amount
☐ 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:
☐ Email ☐ Phone (includes texts) - confirm mobile # _____

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*	
Address	
Contact Name	
Phone Number	E-mail/Fax
☐ PATIENT PAYMENT	☐Check (Payable to Ambry Genetics) ☐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: Patient Signature Date:

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Patient Name: _____ DOB: _____

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)

Neurology Test Requisition Form - Page 2 of 4

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
Comprehensive Testing (Required: completed CustomNext-*Neuro* ordering form on page 3)			
☐	CustomNext-*Neuro*	9540	Up to 196 gene custom neurology test
Epilepsy			
☐	EpiRapid *blood only, no saliva*	7033	16 epilepsy genes with treatment associations
☐	EpiRapid reflex to EpilepsyNext *blood only, no saliva*	7034	16 epilepsy genes with treatment associations, reflex to 100 genes for epilepsy
☐	EpiFirst-*Fever*	7011	13 genes for febrile seizures ☐ Check if parental samples are included
☐	EpiFirst-*Focal*	7017	11 genes for non-lesional focal epilepsy ☐ Check if parental samples are included
☐	EpiFirst-*IS*	7013	17 genes for infantile spasms ☐ Check if parental samples are included
☐	EpilepsyNext	7019	100 genes for epilepsy ☐ Check if parental samples are included
☐	Neurodevelopment-*Expanded*	7028	196 genes for epilepsy, ID, ASDs ☐ Check if parental samples are included
Migraine			
☐	Familial hemiplegic migraine	7035	*ATP1A2, CACNA1A, PRRT2, SCN1A* ☐ Check if parental samples are included
Clinical Genomics			
☐	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)
☐	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
☐	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: _____
☐	ExomeNext-*Proband*	9993	Proband only exome sequencing Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Proband* plus mtDNA^	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Trio*	9995	Trio exome sequencing Candidate (Novel) Genetic Etiologies: ☐ Opt-out Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Trio* plus mtDNA^	9996	Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: ☐ Opt-out Secondary Findings^^: ☐ Opt-out
Order through AP*	ExomeNext-*Select*	9500	Up to 500 gene custom exome sequencing test

^Mitochondrial (mtDNA) testing cannot be performed on saliva samples.
^^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*

Check to order	Test Name	Test Code	Description
Neurodevelopmental Disorders			
☐	Rett syndrome	2026	*MECP2*
☐	AutismNext	7024	48 genes for syndromic and non-syndromic ASDs ☐ Check if parental samples are included
☐	Autism, macrocephaly	2106	*PTEN*
☐	Fragile X syndrome	4544	*FMR1* repeat expansion analysis and methylation studies
☐	IDNext	7027	140 genes for syndromic and non-syndromic ID ☐ Check if parental samples are included
☐	Neurodevelopment-*Expanded*	7028	196 genes for ID, ASDs, and epilepsy ☐ Check if parental samples are included
Dystrophinopathies			
☐	Duchenne/Becker muscular dystrophy	6314	DMD deletion/duplication analysis via *MLPA*
Hereditary Neuropathy			
☐	Familial transthyretin amyloidosis	1560	*TTR*
Neurocutaneous/Neuro-Oncology Disorders			
☐	Ataxia-telangiectasia	9014	*ATM*
☐	BrainTumorNext	8847	27 genes for brain tumors
☐	HHTNext	8672	*ACVRL1, ENG, SMAD4, GDF2, RASA1*
☐	Legius syndrome	5724	*SPRED1*
☐	Li-Fraumeni syndrome	2866	*TP53*
☐	Neurofibromatosis 1	5704	*NF1*
☐	Neurofibromatosis 2	9024	*NF2*
☐	Nevoid basal cell carcinoma syndrome/ Gorlin syndrome	5684	*PTCH1*
☐	Schwannomatosis	7180	*SMARCB1*
☐	Tuberous sclerosis	5904	*TSC1, TSC2*
☐	von Hippel-Lindau	2606	*VHL*

SINGLE SITE ANALYSIS
(Please include a copy of relative's report)

Gene(s): _____ Mutation(s): _____
Relative Name: _____
Relationship to Relative: _____ Accession # (If tested at Ambry): _____
Positive control sample: ☐ will be provided ☐ already at Ambry ☐ not available

FOR PRENATAL SPECIMENS ONLY: MATERNAL CELL CONTAMINATION
(Both test codes required for fetal specimens)

- ☐ 1260 MCC for amniotic fluid culture or CVS (run concurrently with test)
- ☐ 1262 MCC Reference for maternal blood sample (No Charge)

FAMILY HISTORY (Completion of this section is required for order including parental samples. If available, please also submit a 3-generation pedigree)

Relative	Name	DOB	Affected status*	Samples included?	Secondary findings**
			☐ yes ☐ no	☐	☐ opt in ☐ opt out
			☐ yes ☐ no	☐	☐ opt in ☐ opt out

** If affected, please list symptoms and age at diagnosis*
*** If reflexing to whole exome sequencing, please indicate opt-in or opt-out of the ACMG Secondary Findings minimum list*

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Patient Name: _____ DOB: _____

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CustomNext-*Neuro* (9540) Ordering Form - Page 3 of 4

(This form is ONLY required if ordering CustomNext-*Neuro*, test code 9540)

PATIENT INFORMATION

Last Name	First Name	Middle Initial	DOB (MM/DD/YY)

CUSTOMIZE YOUR PANEL

To create your own panel, add all desired genes below **OR** select one of the following multi-gene tests and add or remove all desired genes below.
All genes include sequencing and deletion/duplication analysis.

- ☐ EpiFirst-*Fever*: 13 genes for febrile seizures
- ☐ EpiFirst-*IS*: 17 genes for infantile spasms
- ☐ EpiFirst-*Focal*: 11 genes for non-lesional focal epilepsy
- ☐ EpilepsyNext: 100 genes for epilepsy
- ☐ AutismNext: 48 genes for autism specturm disorder
- ☐ IDNext: 140 genes for intellectual disability
- ☐ Neurodevelopment-*Expanded*: All 196 genes in CustomeNext-*Neuro*

A list of genes for each multi-gene test is available on ambrygen.com

- ☐ Rett/Angelman syndrome: 22 genes associated with Rett syndrome, Angelman syndrome, and phenocopies (*ARX, ATRX, CDKL5, CNTNAP2, DYRK1A, EHMT1, FOXG1, IQSEC2, MBD5, MECP2, MEF2C, NRXN1, PCDH19, PNKP, SATB2, SHANK3, SLC2A1, SLC9A6, STXBP1, TCF4, UBE3A, ZEB2*)
- ☐ Batten disease: 13 genes associated with NCLs, or Batten disease (*ATP13A2, CLN3, CLN5, CLN6, CLN8, CTSD, CTSF, DNAJC5, GRN, KCTD7, MFSD8, PPT1, TPP1*)

CUSTOM GENE SELECTION (Check "+" to add and "-" to remove)

+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-
☐	*ABCD1*	☐	☐	*CREBBP*	☐	☐	*GNAO1*	☐	☐	*MAOA*	☐	☐	*PNPO*	☐	☐	*SMARCA2*	☐
☐	*ACSL4*	☐	☐	*CRH*	☐	☐	*GOSR2*	☐	☐	*MBD5*	☐	☐	*POGZ*	☐	☐	*SMARCA4*	☐
☐	*ADNP*	☐	☐	*CSTB*	☐	☐	*GPC3*	☐	☐	*MECP2*	☐	☐	*POLG*	☐	☐	*SMARCB1*	☐
☐	*ALDH7A1*	☐	☐	*CTCF*	☐	☐	*GRIA3*	☐	☐	*MED12*	☐	☐	*PORCN*	☐	☐	*SMC1A*	☐
☐	*ALG13*	☐	☐	*CTSD*	☐	☐	*GRIN1*	☐	☐	*MED23*	☐	☐	*PPT1*	☐	☐	*SMC3*	☐
☐	*ANKRD11*	☐	☐	*CTSF*	☐	☐	*GRIN2A*	☐	☐	*MEF2C*	☐	☐	*PQBP1*	☐	☐	*SMS*	☐
☐	*AP1S2*	☐	☐	*CUL4B*	☐	☐	*GRIN2B*	☐	☐	*MFSD8*	☐	☐	*PRICKLE1*	☐	☐	*SNAP25*	☐
☐	*AP4B1*	☐	☐	*DCX*	☐	☐	*GRN*	☐	☐	*MID1*	☐	☐	*PRRT2*	☐	☐	*SPTAN1*	☐
☐	*ARHGEF9*	☐	☐	*DDX3X*	☐	☐	*HCN1*	☐	☐	*NDP*	☐	☐	*PTCHD1*	☐	☐	*ST3GAL3*	☐
☐	*ARID1B*	☐	☐	*DEPDC5*	☐	☐	*HDAC8*	☐	☐	*NDUFA1*	☐	☐	*PTEN*	☐	☐	*STX1B*	☐
☐	*ARX*	☐	☐	*DHCR7*	☐	☐	*HNRNPU*	☐	☐	*NHLRC1*	☐	☐	*PTPN11*	☐	☐	*STXBP1*	☐
☐	*ATP13A2*	☐	☐	*DLG3*	☐	☐	*HOXA1*	☐	☐	*NHS*	☐	☐	*PURA*	☐	☐	*SYN1*	☐
☐	*ATP1A2*	☐	☐	*DNAJC5*	☐	☐	*HPRT1*	☐	☐	*NIPBL*	☐	☐	*RAB39B*	☐	☐	*SYNGAP1*	☐
☐	*ATP7A*	☐	☐	*DNM1*	☐	☐	*HUWE1*	☐	☐	*NLGN3*	☐	☐	*RAD21*	☐	☐	*SZT2*	☐
☐	*ATRX*	☐	☐	*DYNC1H1*	☐	☐	*IDS*	☐	☐	*NLGN4X*	☐	☐	*RAI1*	☐	☐	*TBC1D24*	☐
☐	*BRWD3*	☐	☐	*DYRK1A*	☐	☐	*IQSEC2*	☐	☐	*NRXN1*	☐	☐	*RPL10*	☐	☐	*TBL1XR1*	☐
☐	*CA8*	☐	☐	*EEF1A2*	☐	☐	*KAT6A*	☐	☐	*NSD1*	☐	☐	*RPS6KA3*	☐	☐	*TBR1*	☐
☐	*CACNA1A*	☐	☐	*EHMT1*	☐	☐	*KATNAL2*	☐	☐	*NSUN2*	☐	☐	*SATB2*	☐	☐	*TCF4*	☐
☐	*CACNA1C*	☐	☐	*EPM2A*	☐	☐	*KCNA2*	☐	☐	*OCRL*	☐	☐	*SCARB2*	☐	☐	*TIMM8A*	☐
☐	*CASK*	☐	☐	*FGD1*	☐	☐	*KCNC1*	☐	☐	*OFD1*	☐	☐	*SCN1A*	☐	☐	*TPP1*	☐
☐	*CC2D1A*	☐	☐	*FLNA*	☐	☐	*KCNJ10*	☐	☐	*OPHN1*	☐	☐	*SCN1B*	☐	☐	*TRAPPC9*	☐
☐	*CDKL5*	☐	☐	*FMR1* *	☐	☐	*KCNQ2*	☐	☐	*OTC*	☐	☐	*SCN2A*	☐	☐	*TSC1*	☐
☐	*CHD2*	☐	☐	*FOLR1*	☐	☐	*KCNQ3*	☐	☐	*PACS1*	☐	☐	*SCN8A*	☐	☐	*TSC2*	☐
☐	*CHD7*	☐	☐	*FOXG1*	☐	☐	*KCNT1*	☐	☐	*PAK3*	☐	☐	*SHANK3*	☐	☐	*TUSC3*	☐
☐	*CHD8*	☐	☐	*FOXP1*	☐	☐	*KCTD7*	☐	☐	*PCDH19*	☐	☐	*SIK1*	☐	☐	*UBE2A*	☐
☐	*CHRNA2*	☐	☐	*FOXP2*	☐	☐	*KDM5C*	☐	☐	*PDHA1*	☐	☐	*SLC13A5*	☐	☐	*UBE3A*	☐
☐	*CHRNA4*	☐	☐	*FTSJ1*	☐	☐	*KIAA2022*	☐	☐	*PHF6*	☐	☐	*SLC16A2*	☐	☐	*UPF3B*	☐
☐	*CHRNB2*	☐	☐	*GABRA1*	☐	☐	*KIF1A*	☐	☐	*PHF8*	☐	☐	*SLC25A22*	☐	☐	*VPS13B*	☐
☐	*CLN3*	☐	☐	*GABRB3*	☐	☐	*L1CAM*	☐	☐	*PIGA*	☐	☐	*SLC2A1*	☐	☐	*WDR45*	☐
☐	*CLN5*	☐	☐	*GABRG2*	☐	☐	*LAMP2*	☐	☐	*PIGN*	☐	☐	*SLC35A2*	☐	☐	*ZC4H2*	☐
☐	*CLN6*	☐	☐	*GAMT*	☐	☐	*LGI1*	☐	☐	*PLCB1*	☐	☐	*SLC6A1*	☐	☐	*ZEB2*	☐
☐	*CLN8*	☐	☐	*GATM*	☐	☐	*LINS*	☐	☐	*PLP1*	☐	☐	*SLC6A8*	☐			
☐	*CNTNAP2*	☐	☐	*GDI1*	☐	☐	*MAN1B1*	☐	☐	*PNKP*	☐	☐	*SLC9A6*	☐			

FMR1 CGG repeat analysis as an additional test bill separately (test code 4544)* ☐ **ADD

Total Gene Count (REQUIRED: include total number of genes on your CustomNext-*Neuro* panel): _____

Notes:

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Patient Name: _____ DOB: _____

ExomeNext Medical Necessity Form - Page 4 of 4

REQUIRED FOR INSURANCE ORDERS ONLY

This form is ONLY required if you are requesting reflex to Exome sequencing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

☐ Yes, date performed: _____

☐ No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

☐ Multiple abnormalities affecting unrelated organ systems (please specify): _____

OR two of the following:

☐ Abnormality affecting a single organ system(specify): _____

☐ Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)

☐ Family history strongly implicating a genetic etiology (please specify findings and relationships)

☐ Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

☐ Yes (please describe): _____

☐ No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

☐ Chromosomal microarray

☐ Single gene test(s): _____

☐ Multigene panel(s): _____

☐ Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

☐ Imaging study: _____

☐ Surgery: _____

☐ Biopsy: _____

☐ Other: _____