Ambry Genetics®

Expanded Secondary Findings Request Form

For an additional cost, patients and family members chosen as part of the trio may also order an expanded secondary findings report. The family members chosen as the ExomeNext trio are at the discretion of the laboratory. **Thus, not all consented family members may receive expanded secondary findings reports.** In addition to the ACMG recommended list, each patient can choose from an expanded set of reportable secondary findings consisting of four categories: recessive carrier status, cancer predisposition, adult onset disease and childhood onset disease. Please note, DNA variants associated with drug metabolism and risk of common multifactorial diseases (*i.e.* coronary artery disease, obesity, asthma, etc.) are not analyzed and reported as part of the expanded secondary findings report. Expanded secondary findings will only be reported for the proband and members of the trio, however single site analysis can be ordered for other family members if desired. Please note, pathogenic mutations that may be present in a family member but not in the proband may be detected and reported.

A complete list of genes from the four expanded secondary findings categories described above can be found at: www.ambrygen.com/exomenext-forms

Please complete one form per patient/family member.

PLEASE CHOOSE FROM THE EXPANDED SECONDARY FINDINGS BELOW:

____ Recessive disease carrier status: $400
(Carrier status of genes associated with significant human disease that may impact reproductive decision making)

____ Cancer predisposition: $400
(Mutations in genes that may increase the risk of developing cancer)

____ Adult onset disease predisposition: $400
(Mutations in genes that may increase the risk of later-onset disease)

____ Childhood onset disease: $400
(Mutations in genes that may increase the risk of disease which may manifest before the age of 18)

BILLING INFORMATION (credit card payments are the only method of payments accepted)

Cardholder: _____ Account Number: _____

Exp. Date: _____ Amount to Charge: _____

Billing Address: _____

Signature: _____

PATIENT ACKNOWLEDGEMENT: I affirm that my clinician has offered genetic counseling and has reviewed with me the expanded secondary findings testing process prior to testing, and I would like to proceed with test processing.

Patient Name: _____ Date of Birth: _____

Patient (Guardian) Signature: _____ Date: _____

CONFIRMATION OF INFORMED CONSENT FOR GENETIC TESTING: By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order genetic testing; acknowledges the patient has been supplied information regarding genetic testing for the expanded secondary findings options listed above and the patient has given consent for genetic testing to be performed and the signed consent form is on file.

Ordering Clinician Name: _____ Date: _____

Clinician Signature: _____

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