AmbryShare Research Exome Requisition Form (20103)

PLEASE COMPLETE ENTIRE FORM

Ambry Genetics
7 Argonaut, Aliso Viejo, CA 92656 USA
Toll Free: 866.262.7943 Ext. 4113 | Fax: 949.861.9374
share@ambrygen.com | ambrygen.com

RESEARCH PARTICIPANT INFORMATION

Name (Last, First, MI)

DOB (MM/DD/YY)	Biological Sex ☐F ☐M	Phone Number/Email

Address | City | State | Zip

Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ☐Other:

Parent/Legal Guardian Name | Phone Number/Email

SPECIMEN INFORMATION*

Type(s) ☐ Blood (EDTA preferred) ☐ Blood (PAX gene tubes for RNA)

☐ Saliva (spit kit) ☐Saliva (pediatric)

☐DNA, Source: ☐Other:

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

**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.

Collection Date

Have you completed the AmbryShare consent form? ☐Yes ☐No

If **YES**, and you selected to download and sign the consent, please include the ORIGINAL copy with this form and sample.

If **NO**, please go to www.ambryshare.com to read and sign the consent form.

STUDY YOU ARE SUBMITTING SAMPLE FOR

Check to enroll	Test Name	Test Code
☐	AmbryShare - Prostate Cancer	9702
☐	AmbryShare - Autism	9701
☐	AmbryShare - Unspecified	9799

FOR **AUTISM STUDY**, PLEASE COMPLETE THE FOLLOWING:

Is this participant the proband?

☐Yes ☐No

If NO, please answer the questions below.

What is the relationship to the proband?

☐Biological mother
☐Biological father
☐Other

What is the proband's name and date of birth?
(applicable only if this sample is for a family member)

Proband Name

DOB (MM/DD/YY)

CLINIC INVOLVED IN ENROLLMENT PROCESS (If applicable)

Facility Name (Facility Code) | Address | City | State /Country | Zip | Phone

CLINICAL INFORMATION (Please include a copy of relevent clinical history)

☐Unaffected ☐Affected/Symptomatic, age at diagnosis:

PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)

Previously Detected Alteration(s)	Gene Name	Testing Lab	Was the participant tested previously at Ambry? ☐Yes ☐No

FAMILY HISTORY (Please include a copy of a 3 generation pedigree if available)

☐ None (maternal) ☐ Maternal history unknown ☐ None (paternal) ☐ Paternal history unknown

Relation to patient	Maternal	Paternal	Diagnosis	Dx age	Family member submitting sample to AmbryShare
	☐	☐			☐ Yes ☐ No Name:
	☐	☐			☐ Yes ☐ No Name:
	☐	☐			☐ Yes ☐ No Name:
	☐	☐			☐ Yes ☐ No Name:

CONTACT US

Questions about this study, contact:

Clinical Research Coordinator
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