

# GENERAL TEST REQUISITION

## Online Order Form

Arrows "▶" Mandatory for Processing

Perform Preverification  
Prior to Sample Testing

Patient Information		Contact and Organization Information	
▶ <b>DOB</b> MM - DD - YEAR	▶ <b>Last Name, First Name</b> Middle Initial (i.e. Smith, John W)	▶ <b>Org ID</b>	▶ <b>Org Name</b>
▶ <b>Gender</b> F M	▶ <b>Street Address</b>	Address	Suite
▶ <b>Ethnicity</b> African American Caucasian Hispanic Asian Jewish (Ashkenazi) Specify:	<b>City</b>	City	State Zip
	<b>Home Phone</b>	Phone	Fax
		▶ <b>Contact ID</b>	
		▶ <b>Physician Name</b>	
		Address	Suite
		City	State Zip
		Phone	Fax
		Email	
		NPI#	
		▶ <b>2nd Contact ID</b>	
		▶ <b>2nd Contact Name</b>	
		Address	Suite
		City	State Zip
		Phone	Fax
		Email	
		▶ <b>3rd Contact ID</b>	
		▶ <b>3rd Contact Name</b>	
		Address	Suite
		City	State Zip
		Phone	Fax
		Email	
		▶ <b>Form Completed by</b>	
		▶ <b>Phone</b>	
▶ <b>Specimen</b>		▶ <b>Previous Test History</b>	
▶ <b>Collection Date:</b>		Previously Detected Mutations:	
Specimen ID:		Testing Lab:	
MR#:		Patient previously tested at Ambry: Yes No	
Specimen Type (See Requirements)		Family previously tested at Ambry: Yes No	
Blood		Name: Relation:	
Blood Spot		Name: Relation:	
DNA		Name: Relation:	
Cultured Amniocytes		Name: Relation:	
Cultured CVS		Name: Relation:	
CVS Tissue		Name: Relation:	
Other:			
▶ <b>Medical Professional Signature*</b> Mandatory for Medicare/Medicaid		▶ <b>Consent</b>	
By ordering testing, the medical professional or authorized person acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient.		Does this patient give consent to the use of their sample for research? Yes No <i>Consent is implied if a box is not marked. Sample will be made anonymous.</i>	
X _____ Date: _____		* MD/DO, Clinical Nurse Specialist, Nurse-Midwives, Nurse Practitioner, Physician Assistant	
▶ <b>Billing Information - Mandatory For Processing</b>			
AMBRY GENETICS provides a selection of convenient billing options. Please choose an option below and supply all requested information for your selection. Keep in mind that patient testing will be delayed until all of the billing requirements have been met. Choose an option below.			
▶ <b>Bill Facility</b> same as ordering facility		▶ <b>Bill Insurance</b> Include card copy (both sides)	
Facility Name		A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients. Ambry will pre-verify patient insurance coverage and if estimated patient out-of-pocket costs exceed \$350, Ambry will not perform testing until patient is notified.	
Address Suite		Name of Insured	
City State		Relation to patient? Self Parent Spouse	
Zip		Insurance Name	
Phone Fax		Address Suite	
Contact Person		City State	
Contact Person Phone		Zip ICD9	
		Phone Fax	
		Member ID # Group #	
		Authorization # Date	
		▶ <b>Pre-Payment</b>	
		Payment Type Check Mastercard Discover Visa American Express	
		Card Number Exp Date	
		Cardholder Name Amount \$	
		Signature Date X	
		▶ <b>Patient Acknowledgement</b>	
		I hereby authorize my insurance benefits to be paid directly to Ambry Genetics Corporation and authorize them to release medical information concerning my testing to my insurer. I hereby acknowledge I am financially responsible for any amounts not paid by insurer.	
		X _____ Date	

**MARK A TEST ON SUBSEQUENT PAGES FOR PROCESSING**

Thank You for Choosing Ambry Genetics

► **Test Directory** **Requisition Form**

Note any additional test requests here (i.e. run simultaneously, call before proceeding to next test, test not seen on drop down menu, etc)

**Special Test Request Section**

If requesting a specific mutation analysis, please note the mutations here:  
 If requesting a "Flex" panel (Ashkenazi or Thrombophilia), please note which genes you would like tested here:  
 If requesting a Cystic Fibrosis test, note if you would like the Poly T/TG status reported or Poly T status only  
 Report amino acid changing polymorphisms (silent polymorphisms available on request): Yes

**List Any Clinical Findings (attach pedigree to printed req form and send in with sample)**

► **Indication for Testing**

- Diagnostic
- Carrier Screening
- Research
- Positive Newborn Screen
- Family History
- Other:

**Family History of Cancer** (Indicate relationship and Maternal (M) or Paternal (P), site or adenoma #, and age at dx.)

No known Family History

Relationship M/P:	Site/Adenoma#:	Dx Age:
Relationship M/P:	Site/Adenoma#:	Dx Age:
Relationship M/P:	Site/Adenoma#:	Dx Age:
Relationship M/P:	Site/Adenoma#:	Dx Age:

**Patient History of Cancer** No Personal History

Colorectal, Invasive\* Diagnosis Age:  
 Adenomatous Polyps Diagnosis Age:  
 Cumulative #: 1 2-5 6-9 10-19 20-99 100+  
 Endometrial/Uterine Diagnosis Age:  
 Other: Diagnosis Age:  
 If MSI/IHC Testing Was Performed, Please Provide Results:

**Additional Neurological Clinical Information** (Required for complimentary family studies, if indicated) Please attach pedigree / clinical consultation notes, if available.

**Intellectual delay/mental retardation**

- ID/MR mild moderate severe profound Overall IQ:
- Verbal Aptitude normal mild deficiency moderate deficiency non-verbal
- Autism no autistic behaviors autistic behaviors (describe):

**Dysmorphic features (describe):**

**Congenital anomalies (describe):**

**History of Seizures** No Yes diagnosed epilepsy

**Previous Studies**

MRI/CT studies (findings):  
 Chromosome analysis:  
 Microarray analysis:  
 Other molecular studies:

**Growth indices**

Head circumference: % Weight: % Height: %

The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory: 1) Proband report (mandatory) and 2) Positive Control (recommended). Positive Control Not Available Positive Control Sent / To Be Sent  
 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.