

**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"/> 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 [ambrygen.com/specimen-requirements](http://ambrygen.com/specimen-requirements) for details.

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):

**PRENATAL SAMPLES ONLY**

Sample type: <input type="checkbox"/> Direct CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured amnio <input type="checkbox"/> POC <input type="checkbox"/> Cultured POC	Gestational age at sample collection
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**ORDERING LICENSED PROVIDER/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		

**ADDITIONAL RESULTS RECIPIENTS**

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	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 ).

**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 #
Amby Genetics preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed (Nothing checked defaults to >\$100): <input type="checkbox"/> \$100 <input type="checkbox"/> Any amount <input type="checkbox"/> Other \$		Contact Name
<input type="checkbox"/> Hold order pending patient contact and approval of payment terms regarding out-of-pocket. Patient preferred method of contact regarding out-of-pocket amount: <input type="checkbox"/> Email <input type="checkbox"/> Phone		Phone Number
		E-mail/Fax
		<input type="checkbox"/> <b>PATIENT PAYMENT</b> <input type="checkbox"/> Check (Payable to Amby Genetics) <input type="checkbox"/> 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 Amby Genetics Corporation (Amby), authorize Amby 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 Amby money received from my health insurance company.  
**For patient payment by credit card:** I hereby authorize Amby Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Amby'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 Amby Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

**Research & Recontact Consent:** For more information on research at Amby Genetics, please visit [ambrygen.com/patient-resources](http://ambrygen.com/patient-resources). **NOTE:** If left blank, consent is interpreted as "NO".  
 I agree to use of my de-identified biospecimen for research to improve genetic testing for all patients and contribute to scientific research.  
 I am a New York state resident and I give Amby Genetics permission to store my sample for up to 1 year after testing completion.  
 In addition to agreeing above, I agree to be contacted by Amby Genetics regarding research opportunities.

**Signature Required for Insurance/Self-Pay Patients and Research Consent** Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Comprehensive Test Requisition Form - Page 2 of 7

**CLINICAL HISTORY**
**PLEASE ATTACH PEDIGREE /CLINICAL CONSULTATION NOTES, IF AVAILABLE**

<b>Birth and Neonatal History</b> <input type="checkbox"/> Not Applicable  Gestational age at birth: _____ Birth weight: _____ Head circumference at birth (if available): _____ <input type="checkbox"/> Congenital anomalies, explain: _____ <input type="checkbox"/> Positive newborn screen, explain: _____	<b>Developmental History</b> <input type="checkbox"/> Not Applicable  Developmental delay: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Delay prior to seizure onset: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> N/A Type of delay (choose all that apply): <input type="checkbox"/> motor <input type="checkbox"/> language <input type="checkbox"/> global Intellectual disability: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Regression or plateau: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder?: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown
<b>Seizure History</b> <input type="checkbox"/> Not Applicable  Age at first unprovoked seizure (first seizure without fever or other acute metabolic or structural cause): _____ Seizure types (choose all that apply): <input type="checkbox"/> Infantile/epileptic spasms <input type="checkbox"/> Myoclonic <input type="checkbox"/> Generalized tonic clonic <input type="checkbox"/> Tonic <input type="checkbox"/> Typical absence <input type="checkbox"/> Focal seizures <input type="checkbox"/> Atonic <input type="checkbox"/> Atypical absence Are seizures: <input type="checkbox"/> refractory <input type="checkbox"/> well-controlled Has this patient been diagnosed with an epilepsy syndrome? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown If yes, please specify: _____	<b>Cardiac History</b> <input type="checkbox"/> Not Applicable  Sudden cardiac arrest <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ # Episodes: _____ Age first incident: _____ Syncope <input type="checkbox"/> Y <input type="checkbox"/> N If yes, # Episodes: _____ Age first incident: _____ History of cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> HCM <input type="checkbox"/> DCM <input type="checkbox"/> ARVD <input type="checkbox"/> LVNC <input type="checkbox"/> RCM <input type="checkbox"/> Other cardiomyopathy types: _____ History of Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> Long QT <input type="checkbox"/> Short QT <input type="checkbox"/> Brugada <input type="checkbox"/> CPVT <input type="checkbox"/> ARVD <input type="checkbox"/> Other arrhythmia types: _____ <input type="checkbox"/> Congenital heart defect
<b>Pulmonology History</b> <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Positive newborn screen <input type="checkbox"/> CBAVD <input type="checkbox"/> Meconium ileus <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"/> Pancreatic insufficiency IRT level: _____ <input type="checkbox"/> Respiratory distress, explain: _____ <input type="checkbox"/> Respiratory assistance devices: _____ <input type="checkbox"/> Ultrasound findings: _____	<b>Other History</b> <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Hearing problems: _____ <input type="checkbox"/> Vision problems: _____ <input type="checkbox"/> Migraine: _____ <input type="checkbox"/> Psychiatric: _____ <input type="checkbox"/> Hematological: _____ <input type="checkbox"/> Suspected genetic condition: _____ <input type="checkbox"/> Other clinical findings: _____

**Cancer History**  Not Applicable

Cancer/Tumor	Age at Dx	Pathology and Other Info
Brain		
Breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
2nd primary breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
Colorectal		Location:
Ovarian		<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal
Melanoma/skin		
Prostate		Gleason Score: _____ Metastatic: <input type="checkbox"/> Yes <input type="checkbox"/> No
Uterine		
Hematologic*		Type: <input type="checkbox"/> Allogenic bone marrow or peripheral stem cell transplant*
Other Cancer		Type:
GI polyps		<input type="checkbox"/> Adenomatous Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+ <input type="checkbox"/> Other type: Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+

*\*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](http://ambrygen.com/specimen-requirements) for details.*

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

Previously Detected Alteration(s): \_\_\_\_\_ Gene Name: \_\_\_\_\_ Testing Lab: \_\_\_\_\_  
 Patient previously tested at Ambry?  Yes  No Family previously tested at Ambry?  Yes  No  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

**FAMILY HISTORY (Completion of this section is required for orders including parental samples)**

Mother - Name: \_\_\_\_\_ DOB: \_\_\_\_\_  unaffected  affected, list symptoms/dx: \_\_\_\_\_ Dx age: \_\_\_\_\_  
 Father - Name: \_\_\_\_\_ DOB: \_\_\_\_\_  unaffected  affected, list symptoms/dx: \_\_\_\_\_ Dx age: \_\_\_\_\_

Relation to patient	Maternal	Paternal	Disease	Dx age
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

INSURANCE ORDERING CHECKLIST
<input type="checkbox"/> Clinic notes (with pedigree if available)
<input type="checkbox"/> ICD-10 code(s)
<input type="checkbox"/> Clinician & patient signatures
<input type="checkbox"/> Insurer-specific forms (i.e. ABN), if applicable
<input type="checkbox"/> Front/back copy of insurance card(s)

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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).*

ALLERGY AND IMMUNOLOGY			
<input type="checkbox"/>	Angioedema, hereditary	2746	SERPING1

CANCER			
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### Multi-Gene Orders

For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history:

- Adenomatous polyposis (*APC/MUTYH*)
- Hereditary breast and ovarian cancer (*BRCA1/2*)
- Lynch syndrome/HNPCC (*MLH1, MSH2, MSH6, PMS2, EPCAM*)
- Testing is clinically indicated for other gene(s):
- None of the above

To complete your multi-gene order, please select a test option to the right. (See supplemental information on page 7 for details).

<sup>1</sup> If you selected *BRCA1/2*, one of these multi-gene reports may be requested.

<sup>2</sup> If you selected Lynch, one of these multi-gene reports may be requested.

<sup>3</sup> If you selected *APC* and *MUTYH*, one of these multi-gene reports may be requested.

\*Required: completed CustomNext-Cancer supplemental form. [ambrygen.com/forms](http://ambrygen.com/forms)

<input type="checkbox"/>	BrainTumorNext	8847	27 gene brain tumor test <sup>2</sup>
<input type="checkbox"/>	BRCAPlus	8836	6 gene breast cancer test <sup>1</sup>
<input type="checkbox"/>	BRCAPlus-Expanded	8837	8 gene breast cancer test <sup>1</sup>
<input type="checkbox"/>	BreastNext	8820	17 gene breast cancer test <sup>1</sup>
<input type="checkbox"/>	CancerNext	8824	34 gene cancer test <sup>1,2,3</sup>
<input type="checkbox"/>	CancerNext-Expanded	8874	67 gene cancer test <sup>1,2,3</sup>
<input type="checkbox"/>	ColoNext	8822	17 gene colorectal cancer test <sup>2,3</sup>
<input type="checkbox"/>	CustomNext-Cancer	9510	Up to 67 gene custom test*
<input type="checkbox"/>	GYNplus	8835	13 gene ovarian/uterine cancer test <sup>1,2</sup>
<input type="checkbox"/>	MelanomaNext	8849	8 gene melanoma test <sup>1</sup>
<input type="checkbox"/>	OvaNext	8830	25 gene ovarian/breast/uterine cancer test <sup>1,2</sup>
<input type="checkbox"/>	PancNext	8042	13 gene pancreatic cancer test <sup>1,2</sup>
<input type="checkbox"/>	Pancreatitis panel	8022	4 gene pancreatitis test
<input type="checkbox"/>	PGLNext	5504	12 gene PGL/PCC test
<input type="checkbox"/>	ProstateNext	8845	14 gene prostate cancer test <sup>1,2</sup>
<input type="checkbox"/>	RenalNext	5900	19 gene renal cancer test <sup>2</sup>

### Single Syndrome Orders

Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
<b>Hereditary Breast and/or Ovarian Cancer</b>				<b>Gastrointestinal Cancer^^ (Cont.)</b>			
<input type="checkbox"/>	<i>ATM</i>	9014	Ataxia-telangiectasia	<input type="checkbox"/>	<i>MSH6</i>	8512	Lynch syndrome
<input type="checkbox"/>	<i>BRCA1/2</i>	8838	Hereditary breast and ovarian cancer	<input type="checkbox"/>	<i>MUTYH</i>	4661	<i>MUTYH</i> -associated polyposis
<input type="checkbox"/>	<i>BRCA1/2</i> del/dup only	5890		<input type="checkbox"/>	<i>PMS2</i>	4646	Lynch syndrome
<input type="checkbox"/>	<i>BRCA1/2</i> Ashkenazi Jewish 3-site mutation panel	5892		<input type="checkbox"/>	<i>POLD1</i> and <i>POLE</i> gene sequence	8877	Polymerase proofreading-associated polyposis
<input type="checkbox"/>	<i>BRCA1/2</i> Ashkenazi Jewish 3-site mutation panel with reflex to <i>BRCA1/2</i> analysis if negative	5894		<input type="checkbox"/>	<i>STK11</i>	2766	Peutz-Jeghers syndrome
<input type="checkbox"/>	<i>CHEK2</i>	9016		<b>Genitourinary Cancer</b>			
<input type="checkbox"/>	<i>DICER1</i>	5260	<input type="checkbox"/>	<i>BAP1</i>	9044	Hereditary leiomyomatosis and renal cell cancer	
<input type="checkbox"/>	<i>PALB2</i>	2366	<input type="checkbox"/>	<i>FH</i>	6301		
<input type="checkbox"/>	<i>PTEN</i>	2106	<i>PTEN</i> -related disorders (including Cowden syndrome)	<input type="checkbox"/>	<i>FLCN</i>	5921	Birt-Hogg-Dubé syndrome
<input type="checkbox"/>	<i>SMARCA4</i>	9028	Rhabdoid tumor predisposition syndrome type 2	<input type="checkbox"/>	<i>VHL</i>	2606	Von-Hippel Lindau disease
<input type="checkbox"/>	<i>TP53</i>	2866	Li-Fraumeni syndrome	<input type="checkbox"/>	<i>TSC1</i> and <i>TSC2</i>	5904	Tuberous sclerosis complex
<b>Gastrointestinal Cancer^^</b>				<b>Endocrine Tumors</b>			
<input type="checkbox"/>	<i>APC</i>	3040	Familial adenomatous polyposis	<input type="checkbox"/>	<i>MAX</i>	9062	Hereditary PGL/PCC
<input type="checkbox"/>	<i>APC</i> and <i>MUTYH</i> concurrent	8726	Adenomatous polyposis	<input type="checkbox"/>	<i>MEN1</i>	2646	Multiple endocrine neoplasia type 1
<input type="checkbox"/>	<i>BMPRIA</i> and <i>SMAD4</i> concurrent	8604	Juvenile polyposis syndrome	<input type="checkbox"/>	<i>RET</i> gene sequence	2680	Multiple endocrine neoplasia type 2
<input type="checkbox"/>	<i>CDH1</i>	4726	Hereditary diffuse gastric cancer	<input type="checkbox"/>	<i>SDHA</i>	9052	Hereditary PGL/PCC
<input type="checkbox"/>	<i>EPCAM</i> del/dup	8519	Lynch syndrome	<input type="checkbox"/>	<i>SDHAF2</i>	9060	Hereditary PGL/PCC
<input type="checkbox"/>	<i>GREM1</i> duplication	8878	Mixed polyposis syndrome	<input type="checkbox"/>	<i>SDHB</i>	9054	Hereditary PGL/PCC
<input type="checkbox"/>	Lynch syndrome (concurrent)	8517	<i>MLH1, MSH2, MSH6, PMS2</i> + <i>EPCAM</i> del/dup	<input type="checkbox"/>	<i>SDHC</i>	9056	Hereditary PGL/PCC
<input type="checkbox"/>	Lynch syndrome (sequential)	8515	Step 1: <i>MLH1, MSH2</i> , and <i>MSH6</i> + <i>EPCAM</i> del/dup; Step 2: <i>PMS2</i>	<input type="checkbox"/>	<i>SDHD</i>	9058	Hereditary PGL/PCC
<input type="checkbox"/>	<i>MLH1</i>	8508	Lynch syndrome	<input type="checkbox"/>	<i>TMEM127</i>	9066	Hereditary PGL/PCC
<input type="checkbox"/>	<i>MSH2</i> + <i>EPCAM</i> del/dup	8510	Includes <i>MSH2</i> inversion	<b>Skin Cancer/Melanoma</b>			
<input type="checkbox"/>	<i>MSH2</i> inversion	2226	Lynch syndrome	<input type="checkbox"/>	<i>CDKN2A</i> and <i>CDK4</i> concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
				<input type="checkbox"/>	<i>PTCH1</i>	5684	Gorlin syndrome
				<b>Other Hereditary Cancer Testing</b>			
				<input type="checkbox"/>	<i>NF1</i>	5704	Neurofibromatosis type 1
				<input type="checkbox"/>	<i>RB1</i>	5426	Hereditary retinoblastoma
				<b>Other Single Syndrome Orders</b>			
<input type="checkbox"/>	Please visit <a href="http://ambrygen.com/hereditary-cancer-single-gene-tests">ambrygen.com/hereditary-cancer-single-gene-tests</a> for details. Test Code(s): _____ Gene/Test Name(s): _____						

^^ If patient has Medicare and only Lynch is being ordered, please order 8515

# Comprehensive Test Requisition Form - Page 4 of 7

CARDIOLOGY							
Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
<b>Thoracic Aortic Aneurysms and Related Disorders</b>				<b>Cardiomyopathy Panels</b>			
<input type="checkbox"/>	TAADNext	8789	22 genes for thoracic aortic aneurysms/dissections	<input type="checkbox"/>	DCMNext	8884	36 genes for dilated cardiomyopathy
<input type="checkbox"/>	Marfan syndrome	8781	<i>FBN1</i>	<input type="checkbox"/>	CMNext without <i>TTN</i>	8886	54 genes for hereditary cardiomyopathy
<input type="checkbox"/>	Marfan reflex to TAADNext	8783	<i>FBN1</i> reflex to TAADNext	<input type="checkbox"/>	CMNext with <i>TTN</i>	8887	55 genes for hereditary cardiomyopathy
<input type="checkbox"/>	Ehlers-Danlos vascular type (EDS IV)	8790	<i>COL3A1</i>	<input type="checkbox"/>	ARVDNext	8904	9 genes for arrhythmogenic right ventricular dysplasia
<input type="checkbox"/>	Ehlers-Danlos reflex to TAADNext	8791	<i>COL3A1</i> reflex to TAADNext	<input type="checkbox"/>	LVNCNext	8906	8 genes for left ventricular non-compaction
<b>Arrhythmia, Long QT, and Brugada Panels</b>				<b>Comprehensive Cardiovascular Panels</b>			
<input type="checkbox"/>	RhythmFirst	8888	12 genes for long QT syndrome	<input type="checkbox"/>	CardioNext without <i>TTN</i>	8910	84 genes for hereditary cardiomyopathies and arrhythmias
<input type="checkbox"/>	RhythmNext	8900	36 genes for inherited arrhythmias	<input type="checkbox"/>	CardioNext with <i>TTN</i>	8911	85 genes for hereditary cardiomyopathies and arrhythmias
<input type="checkbox"/>	RhythmNext Reflex	8901	RhythmFirst reflex to RhythmNext	<input type="checkbox"/>	CustomNext-Cardio^^	9520	Up to 106 gene custom hereditary cardiomyopathies and arrhythmias test
<input type="checkbox"/>	CPVTNext	8902	6 genes for catecholaminergic polymorphic ventricular tachycardia	<b>Familial Hypercholesterolemia</b>			
<b>Cardiomyopathy Panels</b>				<input type="checkbox"/>	FHNext	8680	4 genes ( <i>APOB</i> , <i>LDLR</i> , <i>LDLRAP1</i> , <i>PCSK9</i> , <i>SLC01B1</i> [c.521T>C])
<input type="checkbox"/>	HCMFirst	8935	<i>MYBPC3</i> , <i>MYH7</i>	<b>CLINICAL GENOMICS</b>			
<input type="checkbox"/>	HCMNext	8936	27 genes for hypertrophic cardiomyopathy	<input type="checkbox"/>	Karyotype	3660	High-resolution chromosome analysis (requires green-top sodium-heparin tube)
<input type="checkbox"/>	HCMNext Reflex	8883	HCMFirst reflex to HCMNext	<input type="checkbox"/>	Karyotype, rule out mosaic	3662	High-resolution chromosome analysis (requires green-top sodium-heparin tube)
<b>CLINICAL GENOMICS</b>				<input type="checkbox"/>	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
<input type="checkbox"/>	ExomeNext	9999	<input type="checkbox"/> Opt-out of analysis and reporting of Novel Genetic Etiologies	<input type="checkbox"/>	ExomeNext	9999	<input type="checkbox"/> Opt-out of analysis and reporting of Novel Genetic Etiologies
<input type="checkbox"/>	ExomeNext-Rapid	9999R	<input type="checkbox"/> Opt-out of analysis and reporting of Novel Genetic Etiologies	<input type="checkbox"/>	ExomeNext-Select	9500	Up to 500 gene custom exome sequencing test
<b>ENDOCRINOLOGY</b>				Must be ordered through AP2* *AP2 is AmbyrPort 2.0, our online portal <a href="http://ambrygen.com/ap2">ambrygen.com/ap2</a> If ordering ExomeNext/ExomeNext-Rapid, please complete: <b>Secondary Findings Report:</b> 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). <input type="checkbox"/> Yes: I choose to receive the ACMG Recommended List of secondary findings <input type="checkbox"/> No: I choose to decline the ACMG Recommended List of secondary findings			
<input type="checkbox"/>	Hereditary leiomyomatosis renal cell carcinoma	6301	<i>FH</i>	<input type="checkbox"/>	Neurofibromatosis type 1	5704	<i>NF1</i>
<input type="checkbox"/>	Maturity-onset diabetes of the young	8310	<i>HNFA1</i> , <i>HNFA4</i> , <i>HNFB1</i> , <i>GCK</i> , <i>PDX1</i>	<input type="checkbox"/>	PGLFirst	5419	7 gene non-syndromic PGL/PCC test
<input type="checkbox"/>	Multiple endocrine neoplasia type I	2646	<i>MEN1</i>	<input type="checkbox"/>	PGLNext	5504	12 gene PGL/PCC test
<input type="checkbox"/>	Multiple endocrine neoplasia type 2 and familial medullary thyroid cancer (FMTC)	2680	<i>RET</i> gene sequence	<input type="checkbox"/>	von-Hippel Lindau disease	2606	<i>VHL</i>
<b>GASTROENTEROLOGY</b>				<b>HEMATOLOGY/ONCOLOGY</b>			
<input type="checkbox"/>	Alagille syndrome	1640	<i>JAG1</i>	<input type="checkbox"/>	Wilson disease	1840	<i>ATP7B</i>
<input type="checkbox"/>	Alpha-1 antitrypsin deficiency	1140	<i>SERPINA1</i>	<input type="checkbox"/>	<i>CFTR</i> gene sequence	1000	
<input type="checkbox"/>	Hirschsprung disease ( <i>RET</i> -related)	2680	<i>RET</i> gene sequence	<input type="checkbox"/>	<i>CFTR</i> gene sequence with reflex to deletion/duplication analysis	1006	<input type="checkbox"/> Report poly T/TG status
<input type="checkbox"/>	Juvenile polyposis syndrome	8604	<i>BMPRIA</i> , <i>SMAD4</i>	<input type="checkbox"/>	<i>CFTR</i> gene sequence and deletion/duplication analysis	1007	<input type="checkbox"/> Report poly T/TG status
<input type="checkbox"/>	Pancreatitis	8022	<i>PRSS1</i> , <i>SPINK1</i> , <i>CFTR</i> , <i>CTRC</i>	<b>HEMATOLOGY/ONCOLOGY</b>			
<input type="checkbox"/>	Peutz-Jeghers syndrome	2766	<i>STK11</i>	<input type="checkbox"/>	<i>HBB</i> -related disorders	1048	<i>HBB</i>
<input type="checkbox"/>	DBANext	8550	11 genes for Diamond-Blackfan anemia	<input type="checkbox"/>	Shwachman-Diamond syndrome	1440	<i>SBDS</i>
<input type="checkbox"/>	DCNNext	8161	7 genes for dyskeratosis congenita				

\*Required: completed CustomNext-TAAD Supplemental Ordering Form. [ambrygen.com/forms](http://ambrygen.com/forms)  
 ^^Required: completed CustomNext-Cardio Supplemental Ordering Form. [ambrygen.com/forms](http://ambrygen.com/forms)

# Comprehensive Test Requisition Form - Page 5 of 7

INHERITED METABOLIC DISORDERS							
Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
<b>Lysosomal Storage Disorders</b>				<b>Leukodystrophies</b>			
<input type="checkbox"/>	NCLNext	7025	13 genes for neuronal ceroid lipofuscinosis/Batten disease <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Canavan disease	1226	ASPA
<input type="checkbox"/>	CLN1- Batten	7050	PPT1	<input type="checkbox"/>	Pelizaeus-Merzbacher disease	4180	PLP1
<input type="checkbox"/>	CLN2- Batten	7051	TPP1	<input type="checkbox"/>	X-linked adrenoleukodystrophy	3760	ABCD1
<input type="checkbox"/>	CLN3- Batten	7054	CLN3	<b>Other</b>			
<input type="checkbox"/>	CLN10- Batten	7052	CTSD	<input type="checkbox"/>	Lesch-Nyhan syndrome	3940	HPRT1
<input type="checkbox"/>	Gaucher disease	1820	GBA	<input type="checkbox"/>	Menkes and related syndromes	3800	ATP7A
<input type="checkbox"/>	Hunter syndrome	1940	IDS	<input type="checkbox"/>	Ornithine transcarbamylase (OTC) deficiency	4100	OTC
<input type="checkbox"/>	Niemann-Pick disease, type C	8740	NPC1, NPC2	<input type="checkbox"/>	Wilson disease	1840	ATP7B
<input type="checkbox"/>	Tay-Sachs disease	1240	HEXA				
<b>MULTIPLE CONGENITAL ANOMALIES</b>							
<input type="checkbox"/>	Alagille syndrome	1640	JAG1	<input type="checkbox"/>	Prader-Willi syndrome	2440	Chromosome 15q11.2-q13 methylation studies
<input type="checkbox"/>	CHARGE syndrome	2380	CHD7	<input type="checkbox"/>	RAF1 - Noonan	2320	RAF1
<input type="checkbox"/>	Coffin-Lowry syndrome	4240	RPS6KA3	<input type="checkbox"/>	Rubinstein-Taybi syndrome	7083	CREBBP
<input type="checkbox"/>	CdLSNext - Cornelia de Lange syndrome	7040	NIPBL, SMC1A, HDAC8, RAD21, SMC3	<input type="checkbox"/>	SOS1 - Noonan	2300	SOS1
<input type="checkbox"/>	Kleefstra syndrome	7095	EHMT1	<input type="checkbox"/>	Simpson-Golabi-Behmel syndrome	4420	GPC3
<input type="checkbox"/>	KRAS - Noonan	2340	KRAS	<input type="checkbox"/>	Smith-Lemli-Opitz syndrome	2180	DHCR7
<input type="checkbox"/>	Lowe syndrome	4600	OCRL	<input type="checkbox"/>	Smith-Magenis syndrome	7163	RAI1
<input type="checkbox"/>	Noonan syndrome	8402	PTPN11, SOS1, KRAS, RAF1	<input type="checkbox"/>	Sotos syndrome	7143	NSD1
<input type="checkbox"/>	Oral-facial-digital syndrome	4080	OFD1				
<input type="checkbox"/>	PTPN11- Noonan	2280	PTPN11				
<b>NEUROLOGY</b>							
<b>Ataxia</b>				<b>Epilepsy (Cont.)</b>			
<input type="checkbox"/>	Ataxia-telangiectasia	9014	ATM	<input type="checkbox"/>	Tuberous sclerosis (infantile spasms)	5904	TSC1, TSC2
<b>Epilepsy</b>				<input type="checkbox"/>	EpiFirst-Neonate	7015	10 genes for neonatal seizures <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiRapid **blood only, no saliva**	7033	16 epilepsy genes with treatment associations	<input type="checkbox"/>	EpiFirst-Neonate reflex to EpilepsyNext	7016	10 genes for neonatal seizures, reflex to 100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiRapid reflex to EpilepsyNext **blood only, no saliva**	7034	16 epilepsy genes with treatment associations, reflex to 100 genes for epilepsy	<input type="checkbox"/>	EpilepsyNext	7019	100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included
Please complete the following for any EpiRapid test order: Phone number for verbal results: _____ Name of provider to receive results: _____ Secure email: _____ If there is no answer at the above number, we will send an email to the address provided above. Please send an email prior to shipment including FedEx tracking number to <a href="mailto:receiving@ambrygen.com">receiving@ambrygen.com</a> .				<input type="checkbox"/>	PMEFirst	7020	CSTB, EPM2A, NHLRC1 (includes CSTB repeat expansion) <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	CustomNext-Epilepsy*	9530	Up to 100 gene custom epilepsy test <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	PMENext	7022	21 genes for progressive myoclonus epilepsy (includes CSTB repeat expansion) <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiFirst-Fever	7011	13 genes for febrile seizures <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	PMEFirst reflex to PMENext	7021	CSTB, EPM2A, NHLRC1, reflex to 21 genes for progressive myoclonus epilepsy (includes CSTB repeat expansion) <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiFirst-Fever reflex to EpilepsyNext	7012	13 genes for febrile seizures, reflex to 100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	CSTB repeat expansion	7084	CSTB repeat expansion analysis
<input type="checkbox"/>	EpiFirst-Focal	7017	11 gene for non-lesional focal epilepsy <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Neurodevelopment-Expanded	7028	196 genes for epilepsy, intellectual disability, autism spectrum disorders <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiFirst-Focal reflex to EpilepsyNext	7018	11 gene for non-lesional focal epilepsy, reflex to 100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included	<b>Hereditary Neuropathy</b>			
<input type="checkbox"/>	EpiFirst-IS	7013	17 genes for infantile spasms <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Familial transthyretin amyloidosis	1560	TTR
<input type="checkbox"/>	EpiFirst-IS reflex to EpilepsyNext	7014	17 genes for infantile spasms, reflex to 100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included	<b>Migraine</b>			
				<input type="checkbox"/>	Familial hemiplegic migraine	7035	ATP1A2, CACNA1A, PRRT2, SCN1A <input type="checkbox"/> Check if parental samples are included

 \*Required: completed CustomNext-Epilepsy Supplemental Ordering Form. [ambrygen.com/forms](http://ambrygen.com/forms)

# Comprehensive Test Requisition Form - Page 6 of 7

NEUROLOGY (CONT.)			
Neurodevelopmental Disorders		Neurocutaneous/Neuro-Oncology Disorders	
<input type="checkbox"/>	AutismFirst	7023	16 genes for syndromic autism spectrum disorders <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	AutismNext	7024	48 genes for syndromic and non-syndromic autism spectrum disorders <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	Autism, macrocephaly	2106	<i>PTEN</i>
<input type="checkbox"/>	Fragile X syndrome	4544	<i>FMR1</i> repeat expansion analysis and methylation studies
<input type="checkbox"/>	IDNext	7027	140 genes for syndromic and non-syndromic intellectual disability <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	Neurodevelopment-Expanded	7028	196 genes for intellectual disability, autism spectrum disorders, and epilepsy <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	Angelman syndrome	7029	Methylation studies of 15q11-13, reflex to <i>UBE3A</i>
<input type="checkbox"/>	Rett/AngelmanNext	7026	22 genes for Rett, Angelman, and related syndromes <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	Rett syndrome	2026	<i>MECP2</i>
<input type="checkbox"/>	Ataxia-telangiectasia	9014	<i>ATM</i>
<input type="checkbox"/>	BrainTumorNext	8847	27 genes for brain tumors
<input type="checkbox"/>	HHTFirst	8673	<i>ACVRL1, ENG, SMAD4</i>
<input type="checkbox"/>	HHTNext	8672	<i>ACVRL1, ENG, SMAD4, GDF2, RASA1</i>
<input type="checkbox"/>	HHTFirst reflex to HHTNext	8671	<i>ACVRL1, ENG, SMAD4</i> reflex to <i>GDF2, RASA1</i>
<input type="checkbox"/>	Legius syndrome	5724	<i>SPRED1</i>
<input type="checkbox"/>	Li-Fraumeni syndrome	2866	<i>TP53</i>
<input type="checkbox"/>	Neurofibromatosis 1	5704	<i>NF1</i>
<input type="checkbox"/>	Neurofibromatosis 2	9024	<i>NF2</i>
<input type="checkbox"/>	<i>NF1</i> reflex to Legius	5730	<i>NF1</i> reflex to <i>SPRED1</i>
<input type="checkbox"/>	Nevoid basal cell carcinoma syndrome/ Gorlin syndrome	5684	<i>PTCH1</i>
		9050	<i>SUFU</i>
<input type="checkbox"/>	Schwannomatosis	7180	<i>SMARCB1</i>
<input type="checkbox"/>	Tuberous sclerosis complex	5904	<i>TSC1, TSC2</i>
<input type="checkbox"/>	von Hippel-Lindau disease	2606	<i>VHL</i>

PULMONOLOGY			
Check to order	Test Name	Test Code	Description
Cystic Fibrosis			
<input type="checkbox"/>	508 ONLY	1008	<i>CFTR</i> deltaF508 mutation analysis
<input type="checkbox"/>	508 FIRST	1002	<i>CFTR</i> deltaF508 mutation analysis with reflex to <i>CFTR</i> gene sequence and deletion/duplication
<input type="checkbox"/>	CF 102	1018	102 <i>CFTR</i> disease-causing mutation panel
<input type="checkbox"/>	<i>CFTR</i> gene sequence with reflex to deletion/duplication analysis	1006	<input type="checkbox"/> Report poly T/TG status
<input type="checkbox"/>	<i>CFTR</i> gene sequence and deletion/duplication analysis	1007	<input type="checkbox"/> Report poly T/TG status
<input type="checkbox"/>	<i>CFTR</i> gene sequence	1000	
<input type="checkbox"/>	<i>CFTR</i> deletion/duplication analysis	1004	
<input type="checkbox"/>	Poly T/TG repeat analysis	1010	Poly T repeat analysis with reflex to TG repeat analysis
<input type="checkbox"/>	<i>CFTR</i> SSA	1008	<i>CFTR</i> Single Site Analysis Mutation: _____
Alpha-1 Antitrypsin Deficiency			
<input type="checkbox"/>	Alpha-1 antitrypsin deficiency	1140	<i>SERPINA1</i>
Congenital Central Hypoventilation Syndrome			
<input type="checkbox"/>	Congenital central hypoventilation syndrome	1580	<i>PHOX2B</i> gene sequence
Primary Ciliary Dyskinesia			
<input type="checkbox"/>	PCDNext	8122	21 genes for primary ciliary dyskinesia
Pulmonary Fibrosis			
<input type="checkbox"/>	Telomere-related pulmonary fibrosis	8140	<i>TERT, TERC</i>
Respiratory Distress Syndrome			
<input type="checkbox"/>	Surfactant dysfunction (respiratory distress syndrome)	8100	<i>ABCA3, SFTPB, SFTPC</i> gene sequence
<input type="checkbox"/>	<i>ABCA3</i> -related surfactant dysfunction	1300	<i>ABCA3</i> gene sequence
<input type="checkbox"/>	Surfactant protein B deficiency	1160	<i>SFTPB</i> gene sequence
<input type="checkbox"/>	Surfactant protein C deficiency	1180	<i>SFTPC</i> gene sequence

RHEUMATOLOGY			
<input type="checkbox"/>	Familial Mediterranean fever	5000	<i>MEFV</i>

VASCULAR			
<input type="checkbox"/>	HHTFirst - Hereditary hemorrhagic telangiectasia	8673	<i>ACVRL1, ENG, SMAD4</i>
<input type="checkbox"/>	HHTNext	8672	<i>ACVRL1, ENG, SMAD4, GDF2, RASA1</i>
<input type="checkbox"/>	HHTReflex to HHTNext	8671	<i>ACVRL1, ENG, SMAD4</i> reflex to <i>GDF2, RASA1</i>
<input type="checkbox"/>	<i>GDF2</i> and <i>RASA1</i>	8674	
<input type="checkbox"/>	Ehlers-Danlos type IV, vascular type	8790	<i>COL3A1</i>
<input type="checkbox"/>	EDS IV reflex to TAADNext	8791	<i>COL3A1</i> reflex to TAADNext
<input type="checkbox"/>	TAADNext	8789	22 genes for thoracic aortic aneurysms

**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 (Required for fetal specimens)	
<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)

# Comprehensive TRF - Hereditary Cancer Testing Supplemental Information - Page 7 of 7

## Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	APC, MUTYH
BrainTumorNext (27 genes)	8847	AIP, ALK, APC, CDKN1B, CDKN2A, DICER1, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, POT1, PRKAR1A, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
BRCPlus (6 genes)	8836	BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53
BRCPlus-Expanded (8 genes)	8837	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53
BreastNext (17 genes)	8820	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MRE11A, MUTYH, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, TP53
CancerNext (34 genes)	8824	APC, ATM, BARD1, BRCA1, BRCA2, BRIP1, BMP1A, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1, HOXB13, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, POLD1, POLE, PTEN, RAD50, RAD51C, RAD51D, SMAD4, SMARCA4, STK11, TP53
CancerNext-Expanded (67 genes)	8874	AIP, ALK, APC, ATM, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMP1A, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, DICER1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MITF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
ColoNext (17 genes)	8822	APC, BMP1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
CustomNext-Cancer (up to 67 genes) Required: complete CustomNext-Cancer supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>	9510	AIP, ALK, APC, ATM, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMP1A, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, DICER1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MITF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
GYNplus (13 genes)	8835	BRCA1, BRCA2, BRIP1, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53
HBOC	8838	BRCA1, BRCA2
Lynch syndrome/HNPCC	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup
MelanomaNext (8 genes)	8849	BAP1, BRCA2, CDK4, CDKN2A, MITF, PTEN, RB1, TP53
OvaNext (25 genes)	8830	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMARCA4, STK11, TP53
PancNext (13 genes)	8042	APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
Pancreatitis panel (4 genes)	8022	CFTR, PRSS1, SPINK1, CTRC
PGLNext (12 genes)	5504	FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
ProstateNext (14 genes)	8845	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53
RenalNext (19 genes)	5900	BAP1, EPCAM, FH, FLCN, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL

## Updated Ordering Process (as of June 8, 2016)

We have improved the ordering and reporting process for our hereditary cancer panels. This helps confirm that testing for one or more of the following genes is clinically indicated: APC, BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, MUTYH, and PMS2.

**If you are ordering a multi-gene test**, please first select a clinically indicated condition and complete your order by selecting a multi-gene order.

Please indicate if your patient meets clinical and/or insurance testing criteria, or if the testing is otherwise clinically indicated for one or more of the following conditions:

- Adenomatous polyposis (APC/MUTYH)
- Hereditary breast and ovarian cancer (BRCA1/2)
- Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM)

If testing is not clinically indicated for your patient for any of the listed options, please either fill in the other gene(s) option or select "none of the above".

To complete your multi-gene order, please select one of the appropriate test options and/or select "other" and enter an appropriate test code(s)/test name(s).

**For single gene orders**, please select the appropriate test option or enter the gene(s) and/or test name(s), as well as the relevant test code in the single gene orders section.

For additional details about our single gene testing options, please visit [ambrygen.com/hereditary-cancer-single-gene-tests](http://ambrygen.com/hereditary-cancer-single-gene-tests).

**Example:** For a ColoNext multi-gene order, when Lynch testing is clinically indicated for the patient

CANCER				
Multi-Gene Orders				
For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history:	<input type="checkbox"/>	BrainTumorNext	8847	27 gene brain tumor test <sup>2</sup>
	<input type="checkbox"/>	BRCPlus	8836	6 gene breast cancer test <sup>1</sup>
	<input type="checkbox"/>	BRCPlus-Expanded	8837	8 gene breast cancer test <sup>1</sup>
<input type="checkbox"/> Adenomatous polyposis (APC/MUTYH)	<input type="checkbox"/>	BreastNext	8820	17 gene breast cancer test <sup>1</sup>
<input type="checkbox"/> Hereditary breast and ovarian cancer (BRCA1/2)	<input type="checkbox"/>	CancerNext	8824	34 gene cancer test <sup>1,2,3</sup>
<input checked="" type="checkbox"/> Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM)	<input type="checkbox"/>	CancerNext-Expanded	8874	67 gene cancer test <sup>1,2,3</sup>
<input type="checkbox"/> Testing is clinically indicated for other gene(s):	<input checked="" type="checkbox"/>	ColoNext	8822	17 gene colorectal cancer test <sup>2,3</sup>
<input type="checkbox"/> None of the above	<input type="checkbox"/>	CustomNext-Cancer	9510	Up to 67 gene custom test <sup>1</sup>
	<input type="checkbox"/>	GYNplus	8835	13 gene ovarian/uterine cancer test <sup>1,2</sup>
<b>To complete your multi-gene order</b> , please select a test option to the right. (See supplemental information on page 7 for details).	<input type="checkbox"/>	MelanomaNext	8849	8 gene melanoma test <sup>1</sup>
	<input type="checkbox"/>	OvaNext	8830	25 gene ovarian/breast/uterine cancer test <sup>1,2</sup>
	<input type="checkbox"/>	PancNext	8042	13 gene pancreatic cancer test <sup>1,2</sup>
	<input type="checkbox"/>	Pancreatitis panel	8022	4 gene pancreatitis test
	<input type="checkbox"/>	PGLNext	5504	12 gene PGL/PCC test
	<input type="checkbox"/>	ProstateNext	8845	14 gene prostate cancer test <sup>1,2</sup>
	<input type="checkbox"/>	RenalNext	5900	19 gene renal cancer test <sup>2</sup>

<sup>1</sup> If you selected BRCA1/2, one of these multi-gene reports may be requested.

<sup>2</sup> If you selected Lynch, one of these multi-gene reports may be requested.

<sup>3</sup> If you selected APC and MUTYH, one of these multi-gene reports may be requested.

\*Required: completed CustomNext-Cancer supplemental form. [ambrygen.com/forms](http://ambrygen.com/forms)