Cardiovascular Test Requisition Form - Page 1 of 2

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

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

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:
1. Clinic Notes 2. Pedigree 3. Insurance Card

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:

FAMILY HISTORY* ☐ None (maternal) ☐ None (paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

**Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigrees and other clinical family history notes should be supplied as well when sending in your order.*

Relation to patient	Mat	Pat	H/o cardio disease	Dx age	Relation to patient	Mat	Pat	H/o cardio disease	Dx age
	☐	☐				☐	☐		
	☐	☐				☐	☐		

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 #

☐ Specimen is post-mortem Date of death: _____ Specimen Type: _____

**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 or a fetal specimen, please see bottom of page 3 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.

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

Additional Results Recipients

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:
We will start testing immediately, unless you check the box below. We will attempt to contact you if your estimated out-of-pocket costs are > USD $100.
☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs
Patient agrees to contact regarding out-of-pocket amount by:
☐ Email ☐ Phone (includes texts) - confirm mobile # _____

Special Billing Notes:

☐ 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 Patient Assistance 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: Date:

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Patient Name: _____ DOB: _____

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INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic ☐ Family history ☐ Positive or normal control ☐ Other_____ ICD-10 code(s): _____

Will patient management be changed depending on the test results? ☐ Yes ☐ No ☐ STAT TEST: Date results needed (if known):_____

CLINICAL HISTORY (PLEASE SUPPLY CLINIC NOTES AND PEDIGREE)

☐ No personal history of cardiovascular disease

Sudden cardiac arrest ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

Syncope ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

History of cardiomyopathy ☐ Y ☐ N Age at dx:_____

Type(s) of cardiomyopathy: _____

History of Arrhythmia ☐ Y ☐ N Age at dx: _____

Type(s) of Arrhythmia: _____

☐ Clinical diagnosis of Marfan Syndrome or other connective tissue disorder

☐ Aortic Aneurysm/Dilation Age at dx:_____ z-score:_____

☐ Other Aneurysm Location:_____ Age at dx:_____

☐ Aortic/Vascular Dissection Location:_____Age at dx:_____

☐ History of familial hypercholesterolemia

☐ Other history: _____

CLINICAL TESTING AND PROCEDURES

LDL-C: _____ Total Cholesterol:_____ Age at Testing:_____

Procedures (*e.g.*: EKG, ECHO, etc.) Age: _____ Result (*e.g.*: LVIDd, PWd, Qtc, etc): _____ Type: _____

Cardiovascular Device implant (eg: Pacemaker, ICD, LVAD, etc.): Age at implantation: _____ Type: _____

PREVIOUS GENETIC TESTING (PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS) ☐ No previous molecular and/or genetic testing

Test	Laboratory	Results

CARDIOVASCULAR TEST OPTIONS

Check to order	Test Name	Test Code	Description
Cardiomyopathy Panels			
☐	HCMNext	8936	30 genes for hypertrophic cardiomyopathy
☐	HCMNext Reflex	8883	*MYBPC3, MYH7* reflex to HCMNext
☐	DCMNext	8884	37 genes for dilated cardiomyopathy
☐	CMNext	8887	56 genes for hereditary cardiomyopathy
☐	ARVCNext	8904	11 genes for arrhythmogenic right ventricular cardiomyopathy
Arrhythmia Panels			
☐	LongQTNext	8890	17 genes for long QT, Brugada and short QT syndromes
☐	RhythmNext	8900	42 genes for long QT syndrome, Brugada and short QT syndromes, CPVT and ARVC
☐	CPVTNext	8902	4 genes for catecholaminergic polymorphic ventricular tachycardia
Aneurysms and Related Disorders			
☐	TAADNext	8789	35 genes for thoracic aortic aneurysms/ dissections, Marfan syndrome, Ehlers-Danlos and related disorders
☐	Marfan reflex to TAADNext	8783	*FBN1* reflex to TAADNext

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

☐ 1260 MCC for fetal specimen or cord blood (run concurrently with test)
☐ 1262 MCC Reference for maternal blood sample (No Charge)

SPECIFIC 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

Check to order	Test Name	Test Code	Description
Comprehensive Cardiovascular Panels			
☐	CardioNext	8911	92 genes for hereditary cardiomyopathies and arrhythmias
☐	CustomNext-*Cardio*	9520	Up to 167 genes related to hereditary cardiomyopathies, arrhythmias, TAAD, HHT, Noonan, and lipidemias. Required: completed CustomNext-*Cardio* supplemental form. ambrygen.com/forms
Familial Hypercholesterolemia and Lipid Disorders			
☐	FHNext	8680	4 genes (*APOB, LDLR, LDLRAP1, PCSK9*)
☐ Check this box if you would like to have the *SLCO1B1* c.521T>C polymorphism reported with FHNext, which has been associated in medical literature with statin-induced myopathies			
☐	FCSNext (Familial Chylomicronemia Syndrome)	8920	*APOA5, APOC2, GPIHBP1, LMF1, LPL*
☐	Sitosterolemia	8930	*ABCG5, ABCG8*
Hereditary Hemorrhagic Telangiectasia (HHT)			
☐	HHTNext	8672	*ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4*
Noonan Syndrome			
☐	NoonanNext	8402	18 genes for RASopathies
Other			
☐	Transthyretin amyloidosis	1560	*TTR*
☐	SNP Array*	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)

OTHER ORDER

Test Code: _____Test Name: _____

For more information visit ambrygen.com

** Buccal swab accepted for SNP Array*