Ambry Genetics®
A Konica Minolta Company

acer therapeutics
Genetic Testing Program

Test Requisition Form

Partner Code: ACER

PATIENT INFORMATION (Patient must be 18 years or older)

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Phone Number	Email
Address / City / State / Zip	Biological Sex ☐F ☐M	Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish ☐Other:	

SPECIMEN INFORMATION*

Type(s) ☐Blood ☐Saliva ☐Send saliva kit to patient**

☐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 for details.

**By checking this box and submitting the completed form, a saliva kit will be sent to the patient's address above. Your patient will be able to submit a saliva sample directly to Ambry for testing.

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

PATIENT ELIGIBILITY: PLEASE READ CAREFULLY

Patients must have at least 1 of the following clinical symptoms/manifestations related to Vascular Ehlers-Danlos syndrome.

Does the patient have a family history of Vascular Ehlers-Danlos syndrome? ☐ Yes ☐ No ☐ Patient does not know

Existing *COL3A1* mutation in family? ☐ Yes ☐ No ☐ Patient does not know If yes, please indicate testing lab____________

Clinical Diagnosis ☐ Yes *(If yes, complete symptom checklist below)* ☐ No ☐ Patient does not know

SYMPTOM CHECKLIST (Please check if the patient currently has or previously had any of the following clinical manifestations and indicate symptom onset age.)

- ☐ Yes ☐ No Fragile tissues (including arteries, muscles and internal organs) that are prone to rupture
- ☐ Yes ☐ No Thin, translucent skin
- ☐ Yes ☐ No Characteristic facial appearance (thin lips, small chin, thin nose, large eyes)
- ☐ Yes ☐ No Acrogeria (premature aging of the skin of the hands and feet)
- ☐ Yes ☐ No Hypermobility of small joints (i.e. fingers and toes)
- ☐ Yes ☐ No Early-onset varicose veins
- ☐ Yes ☐ No Pneumothorax
- ☐ Yes ☐ No Easy bruising
- ☐ Yes ☐ No Joint dislocations and subluxations (partial dislocations)
- ☐ Yes ☐ No Congenital dislocation of the hips
- ☐ Yes ☐ No Congenital clubfoot
- ☐ Yes ☐ No Receding gums
- ☐ Other ____

Approximately, how many doctors has the patient seen about this condition? ______

CHECK TO ORDER	TEST NAME	TEST CODE	# OF GENES	GENE LIST
Test available in US only.				
☐	Vascular Ehlers-Danlos Syndrome	8790	1	*COL3A1*

Genetic Counseling: Ambry and Acer have partnered to offer no cost, pre- and/or post-test genetic counseling for your patients. Genetic counseling is not required for testing. By checking the boxes below, I agree to allow Ambry to facilitate the provision of pre-test and/or post-test genetic counseling services by a third party.

☐ Yes. I request a pre-test genetic counseling session for my patient. ☐ Yes. I request a post-test genetic counseling session for my patient.

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 testing is medically necessary and test results may impact medical management for the patient. Furthermore, all information on this ordering form is true to the best of my knowledge. I understand that organization and clinician contact information provided may be shared with Acer Therapeutics and may contact you in connection with the program.

Signature Required for Processing Medical Professional Signature: Date:

To request a complimentary specimen collection kit visit: ambrygen.com/clinician/order-sample-kit

© 2019 Ambry Genetics
15 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 ambrygen.com