

# Test Requisition Form

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 <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 <input type="checkbox"/> Other:				

SPECIMEN INFORMATION*		
Type(s) <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Send saliva kit to patient** <input type="checkbox"/> Phlebotomy request*	<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.  
 \*\*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.  
 \* Available for US patients only. 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

## PATIENT ELIGIBILITY: PLEASE READ CAREFULLY

**Patients must be 18 years and older and have a family history of hereditary ATTR amyloidosis OR have at least two of the following symptoms consistent with hereditary ATTR amyloidosis with polyneuropathy.**

Does the patient have a family history of hereditary ATTR amyloidosis?  Yes  No  Patient does not know

SYMPTOM CHECKLIST (Please check if the patient has previously had or currently has any of the following clinical manifestations and indicate symptom onset age.)	
<input type="checkbox"/> Sensory dysfunction (e.g. numbness and tingling in feet and/or hands, sensitivity to pain and temperature, pain in extremities); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Bilateral Carpal tunnel syndrome; <b>Symptom onset age:</b> _____
<input type="checkbox"/> Motor dysfunction (e.g. muscle weakness, impaired balance, difficulty walking); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Lumbar spinal stenosis; <b>Symptom onset age:</b> _____
<input type="checkbox"/> Autonomic dysfunction (e.g., orthostatic hypotension, early satiety, nausea and vomiting, changes in GI motility, erectile dysfunction, bladder dysfunction); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Unintentional weight loss; <b>Symptom onset age:</b> _____
<input type="checkbox"/> Gastrointestinal (diarrhea or constipation not responding to typical therapy, or alternating bouts of diarrhea/constipation); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Myocardial radiotracer ( <sup>99m</sup> Tc-PYP/DPD/HMDP) uptake on bone scintigraphy and the absence of a monoclonal protein in serum or urine; <b>Symptom onset age:</b> _____
<input type="checkbox"/> Heart disease (e.g., shortness of breath, edema, fatigue, palpitations, and arrhythmias); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Histological confirmation and typing of TTR amyloid; <b>Symptom onset age:</b> _____
<input type="checkbox"/> Renal issues (proteinuria or renal insufficiency/failure); <b>Symptom onset age:</b> _____	<input type="checkbox"/> Other _____
Approximately, how many doctors has the patient seen about this condition? _____	

CHECK TO ORDER	TEST NAME	TEST CODE	# OF GENES	GENE LIST
<input type="checkbox"/>	Transthyretin amyloidosis	1560	1	TTR
<input type="checkbox"/>	CardioNext (includes TTR)	8911	92	TTR, ABCC9, ACTC1, ACTN2, ALMS1, ALPK3, AKAP9, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FLNC, FKTN, FXN, GATA4, GATAD1, GLA, GPD1L, HCN4, JAG1, JPH2, JUP, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, LAMA4, LAMP2, LDB3, LMNA, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYOZ2, MYPN, NEXN, NKX2-5, PKP2, PLN, PRKAG2, PTPN11, RAF1, RBM20, RIT1, RYR2, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SCN10A, SNTA1, SOS1, TAZ, TBX1, TBX20, TBX5, TCAP, TECRL, TGFB3, TMEM43, TMPO, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTN, TXNRD2, VCL
<input type="checkbox"/>	NeuropathySelect (includes TTR)	9570	81	TTR, AARS, AIFM1, APOA1, ATL1, ATL3, ATP7A, BICD2, BSCL2, CHCHD10, DCTN1, DNAJB2, DNM2, DNMT1, DST, DYNC1H, EGR2, FAM134B, FBXO38, FGD4, FIG4, FUS, GAN, GARS, GDAP1, GJB1, GNB4, GSN, HARS, HINT1, HSPB1, HSPB8, IGHMBP2, IKBKAP, INF2, KIF1A, LITAF, LMNA, LRSAM1, MARS, MFN2, MORC2, MPZ, MTRR2, NDRG1, NEFH, NEFL, NGF, NTRK1, OPTN, PDK3, PLEKHG5, PMP22, PRDM12, PRPS1, PRX, RAB7A, REEP1, SBF2, SCN10A, SCN11A, SCN9A, SETX, SH3TC2, SIGMAR1, SLC25A46, SLC52A2, SLC52A3, SLC5A7, SPG11, SPTLC1, SPTLC2, TARDBP, TFG, TRPV4, UBA1, VAPB, VRK1, WNK1, YARS, VCP

Genetic Counseling: Ambry and Akcea have partnered with a third-party counseling provider 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 counseling provider.

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

Please provide patient email if genetic counseling is requested.

**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 third parties including Akcea Therapeutics.

Signature Required for Processing Medical Professional Signature:	Date:
To request a complimentary specimen collection kit visit: <a href="http://ambrygen.com/hattr-compass-kits">ambrygen.com/hattr-compass-kits</a>	