Clinical Genomics Family Member Test Requisition Form

COMPLETE TO SUBMIT FAMILY MEMBERS FOR EXOME ORDERS

All family member specimens must be received within 4 weeks of order to be included in analysis

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

COLLECTION DATE (REQUIRED)

If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)

PATIENT INFORMATION

Legal Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Sex Assigned at Birth ☐F ☐M	Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

Genetic Ancestry: ☐Ashkenazi Jewish ☐Asian ☐Black/African American ☐French Canadian/Cajun ☐Hispanic/Latino ☐Mediterranean ☐Middle Eastern ☐Native American ☐Pacific Islander ☐Portuguese ☐White ☐Unknown ☐Other:

MRN

Address	City	State	Zip

Mobile #	Email	Preferred Billing ☐Insurance ☐Self-pay ☐Institutional

SPECIMEN INFORMATION (Please see ambrygen.com/specimen-requirements for details)

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

☐ Current diagnosis of heme malignancy, Type:

Specimen ID	Medical Record #

Collection Assistance: ☐Phlebotomy draw** ☐Insurance preverification first ☐Send saliva kit to patient ☐Send buccal 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.*

CLINICAL INFORMATION

Is family member affected with the same phenotype as the proband? ☐Yes ☐No ☐Partially ☐Possibly, describe: _____

TEST MENU

☐ 9993-9996 Family member for ExomeNext® (no charge)

☐ 9500 Family member for ExomeNext-*Select* (no charge)

☐ 9999R Family member for ExomeNext-*Rapid*® (no charge)

☐ Other _____(Test Code/Test Name)

Proband Name: _____

Relationship to proband: _____

SECONDARY FINDINGS

Secondary findings results are only available for each family member who is fully sequenced as part of the duo/trio.

Check below to opt-out of the ACMG Recommended List of secondary findings. **If left unchecked, secondary findings will be reported for fully sequenced duo/trio family members.** Secondary findings are not available for ExomeNext-*Select* orders.

☐ Opt-out: I choose to decline the ACMG Recommended List of secondary findings.

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 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, as required by the patient's insurance provider. 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:

Family Member Acknowledgement: I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the whole-exome sequencing process prior to testing, and I would like to proceed with test processing. I understand that the primary exome testing is being performed in order to assist analysis for my family member (proband), that a primary report will only be generated for the proband, and that it may be possible to infer information about my results based on the proband's report.

☐ I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at https://www.ambrygen.com/legal/notice-of-privacy-practices.

For NY Residents:

☐ By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.

Family Member/Guardian Signature:_____ Date:_____

For all exome orders, Ambry includes testing for co-segregation analysis (aka: family testing for candidate alterations) if samples are sent before testing begins.

Ambry Genetics®

Supplemental Information

Specimen Requirements

Blood/saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. See ambrygen.com/specimen-requirements for details.

Buccal swab samples from patients with a history of allogenic bone marrow or stem cell transplant should not be used for genetic testing. For these patients, an alternative specimen (e.g. cultured fibroblasts) is required. Testing on buccal swab samples from patients with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended. Please see ambrygen.com/specimen-requirements for details.

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