Ambry Genetics®
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hATTR Compass
Map Your Genetic Journey

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 ☐F ☐M	Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish ☐Other:

NO-COST GENETIC COUNSELING

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.

ALL patients requesting counseling (with negative, positive or VUS result) will be contacted via phone and/or email.

SPECIMEN INFORMATION*

Type(s) ☐Blood ☐Saliva ☐Send saliva kit to patient** ☐Phlebotomy request^ ☐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.*

^ 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 **(for *TTR* results only)**	Fax **(for results)**	Email **(for results)**

Additional Results Recipients

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

PATIENT ELIGIBILITY: Patients must be 18 years and older and have a family history of hereditary ATTR amyloidosis OR have at least 2 of the following symptoms consistent with hereditary ATTR amyloidosis with polyneuropathy

SYMPTOM CHECKLIST (Please check all conditions that apply and indicate symptom onset age)

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

☐ Sensory dysfunction (e.g. numbness and tingling in feet and/or hands, sensitivity to pain and temperature, pain in extremities); **Symptom onset age:**_____

☐ Motor dysfunction (e.g. muscle weakness, impaired balance, difficulty walking); **Symptom onset age:**_____

☐ Autonomic dysfunction (e.g., orthostatic hypotension, early satiety, nausea and vomiting, changes in GI motility, erectile dysfunction, bladder dysfunction); **Symptom onset age:**_____

☐ Gastrointestinal (diarrhea or constipation not responding to typical therapy, or alternating bouts of diarrhea/constipation); **Symptom onset age:**_____

☐ Heart disease (e.g., shortness of breath, edema, fatigue, palpitations, and arrhythmias); **Symptom onset age:**_____

☐ Renal issues (proteinuria or renal insufficiency/failure); **Symptom onset age:**_____

☐ Bilateral carpal tunnel syndrome; **Symptom onset age:**_____

☐ Lumbar spinal stenosis; **Symptom onset age:**_____

☐ Unintentional weight loss; **Symptom onset age:**_____

☐ Myocardial radiotracer (^{99m}Tc-PYP/DPD/HMDP) uptake on bone scintigraphy and the absence of a monoclonal protein in serum or urine; **Symptom onset age:**_____

☐ Histological confirmation and typing of TTR amyloid; **Symptom onset age:**_____

☐ Other symptom(s) of hATTR _____

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

CHECK TO ORDER	TEST NAME	TEST CODE	# OF GENES	GENE LIST
Please select only one test. Tests available in US, Canada and Puerto Rico.				
☐	Transthyretin amyloidosis	1560	1	*TTR*
☐	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, MTMR2, 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*
☐	CardioNext® (includes *TTR*)	8911	92	***TTR***, *ABCC9, ACTC1, ACTN2, AKAP9, ALMS1, ALPK3, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FKTN, FLNC, GATAD1, GLA, GPD1L, HCN4, 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, SCN10A, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SNTA1, SOS1, TAZ, TBX20, TBX5, TCAP, TECRL, TGFB3, TMEM43, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTN, TXNRD2, VCL*

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: **ambrygen.com/hattr-compass-kits**

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Patient Name: _____

DOB: _____

Supplemental Information

CHECK TO ORDER	TEST NAME	TEST CODE				
☐	Specific Site Analysis	1562	Name of relative previously tested at Ambry	Relative Birth Date	Test Accesion # (if available)	Gene(s) to be tested

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