

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

1. Clinic Notes 2. Pedigree 3. Insurance Card and Authorization Documents

2. PATIENT INFORMATION

Name (Last, First, MI)		Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)	MRN
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:				Ashkenazi Jewish <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		City	State	Zip
Phone		Email		

SPECIMEN INFORMATION (For phlebotomy service, select all services you are requesting)

Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Other:	<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant*		
Collection Date	Specimen ID	Medical Record #	
* 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. Please see ambrygen.com/specimen-requirements for details			
Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send blood kit to patient** <input type="checkbox"/> Send saliva 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 LICENSED PROVIDER/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
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, 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:** _____

<input checked="" type="checkbox"/> INSURANCE BILLING (Include copy of both sides of insurance card)		<input type="checkbox"/> INSTITUTIONAL BILLING	
Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name and DOB of Policy Holder (if not self)	Facility Name	<input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #	HMO Auth #	Address
Out Of Pocket: We will start testing immediately, unless you check the box below. We will attempt to contact the patient if the estimated out-of-pocket costs are > USD \$100. <input type="checkbox"/> Do not start testing until the patient approves payment terms regarding estimated out-of-pocket costs. By checking this box, I understand that there will be a delay in starting this test until Ambry is able to reach the patient to communicate OOP costs.		Contact Name	
		Phone Number	E-mail/Fax
Special Billing Notes:		<input type="checkbox"/> PATIENT PAYMENT	
		<input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> 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:** _____

Cancer Test Requisition Form (Comprehensive)- Page 3 of 3

For multiple tests, testing will be run concurrently (initiated at the same time) unless otherwise specified. For reflexive testing (second test starts pending first test outcome), indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported, and the second test will be cancelled; all other findings will automatically reflex (including VUS).

MULTI-GENE ORDERS				
Select the indication for testing:				
<input type="checkbox"/> Hereditary polyposis ¹	<input type="checkbox"/>	BrainTumorNext®	8847	29 gene brain tumor test
<input type="checkbox"/> Lynch syndrome/HNPCC ²	<input type="checkbox"/>	BRCANext™	8855	18 gene breast cancer test
<input type="checkbox"/> Hereditary breast and ovarian cancer ³	<input type="checkbox"/>	BRCANext-Expanded™	8860	23 gene breast cancer test
<input type="checkbox"/> Testing is clinically indicated for other gene(s):	<input type="checkbox"/>	BRCAPlus®	8836	8 gene breast cancer test
<input type="checkbox"/> None of the above	<input type="checkbox"/>	CancerNext®	8824	36 gene cancer test
	<input type="checkbox"/>	CancerNext-Expanded®	8874	77 gene cancer test
	<input type="checkbox"/>	ColoNext®	8822	20 gene colorectal cancer test
	<input type="checkbox"/>	CustomNext-Cancer®	9510	up to 91 gene custom test^ ^
	<input type="checkbox"/>	MelanomaNext®	8849	9 gene melanoma test
	<input type="checkbox"/>	PancNext®	8042	13 gene pancreatic cancer test
	<input type="checkbox"/>	Pancreatitis panel	8022	6 gene pancreatitis test
	<input type="checkbox"/>	PGLNext®	5504	14 gene PGL/PCC test
	<input type="checkbox"/>	ProstateNext®	8845	14 gene prostate cancer test
	<input type="checkbox"/>	RenalNext®	5900	20 gene renal cancer test
<p>To complete your multi-gene order, please select a test option to the right. (See supplemental information on page 4 for details).</p> <p>¹ APC/MUTYH ² MLH1, MSH2, MSH6, PMS2, EPCAM ³ BRCA1/2 ^{^ ^} Required: completed CustomNext-Cancer supplemental form. ambrygen.com/forms</p>				
<input type="checkbox"/> Add +RNAinsight® to selected panel Not available with BRCAPlus (8836), STAT orders, or pancreatitis panel (8022); PAXgene® tube required for RNA				
Add AmbryScore: <input type="checkbox"/> Breast (Supplemental Ordering Form REQUIRED) <input type="checkbox"/> Prostate				

SINGLE SYNDROME ORDERS							
Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
Hereditary Breast and/or Ovarian Cancer				Genitourinary Cancer			
<input type="checkbox"/>	ATM	9014	Ataxia-telangiectasia	<input type="checkbox"/>	BAP1	9044	
<input type="checkbox"/>	BRCA1/2	8838	Hereditary breast and ovarian cancer	<input type="checkbox"/>	FH	6301	Hereditary leiomyomatosis and renal cell cancer
<input type="checkbox"/>	BRCA1/2 Ashkenazi Jewish 3-site mutation panel	5892		<input type="checkbox"/>	FLCN	5921	Birt-Hogg-Dubé syndrome
<input type="checkbox"/>	CHEK2	9016		<input type="checkbox"/>	VHL	2606	Von-Hippel Lindau disease
<input type="checkbox"/>	DICER1	5260		<input type="checkbox"/>	TSC1 and TSC2	5904	Tuberous sclerosis complex
<input type="checkbox"/>	PALB2	2366		Endocrine Tumors			
<input type="checkbox"/>	PTEN	2106		PTEN-related disorders (including Cowden syndrome)	<input type="checkbox"/>	MEN1	2646
<input type="checkbox"/>	TP53	2866	Li-Fraumeni syndrome	<input type="checkbox"/>	RET gene sequence	2680	Multiple endocrine neoplasia type 2
Gastrointestinal Cancer				Skin Cancer/Melanoma			
<input type="checkbox"/>	APC	3040	Familial adenomatous polyposis	<input type="checkbox"/>	CDKN2A and CDK4 concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
<input type="checkbox"/>	APC and MUTYH	8726	Adenomatous polyposis	<input type="checkbox"/>	PTCH1	5684	Gorlin syndrome
<input type="checkbox"/>	BMPR1A and SMAD4	8604	Juvenile polyposis syndrome	Other Hereditary Cancer Testing			
<input type="checkbox"/>	CDH1	4726	Hereditary diffuse gastric cancer	<input type="checkbox"/>	NF1	5704	Neurofibromatosis type 1
<input type="checkbox"/>	EPCAM del/dup	8519	Lynch syndrome	<input type="checkbox"/>	NF2	9024	Neurofibromatosis type 2
<input type="checkbox"/>	Lynch syndrome	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup	<input type="checkbox"/>	RB1	5426	Hereditary retinoblastoma
<input type="checkbox"/>	MLH1	8508	Lynch syndrome	<input type="checkbox"/>	SMARCB1	7180	Schwannomatosis
<input type="checkbox"/>	MSH2 + EPCAM del/dup	8510	Includes MSH2 inversion	Other Orders			
<input type="checkbox"/>	MSH2 inversion	2226	Lynch syndrome	<input type="checkbox"/>	Please visit ambrygen.com for a list of available tests.		
<input type="checkbox"/>	MSH6	8512	Lynch syndrome	<input type="checkbox"/>	Test Code(s): _____ Gene/Test Name(s): _____		
<input type="checkbox"/>	MUTYH	4661	MUTYH-associated polyposis	SPECIFIC SITE ANALYSIS (Please include a copy of relative's report)			
<input type="checkbox"/>	PMS2	4646	Lynch syndrome	Gene(s): _____ Mutation(s): _____			
<input type="checkbox"/>	STK11	2766	Peutz-Jeghers syndrome	Relative Name: _____			
				Relationship to Relative: _____ Accession # (if tested at Ambry): _____			
				Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available			

Supplemental Information

Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	APC, MUTYH
BrainTumorNext [®] (29 genes)	8847	AIP, ALK, APC, CDKN1B, CDKN2A, DICER1, EPCAM, LZTR1, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, POT1, PRKAR1A, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
BRCANext [™] (18 genes)	8855	ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53
BRCANext-Expanded [™] (23 genes)	8860	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, RECQL, SMARCA4, STK11, TP53
BRCAPlus [®] (8 genes)	8836	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53
CancerNext ^{®i,††} (36 genes)	8824	APC, ATM, AXIN2, BARD1, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RECQL, SMAD4, SMARCA4, STK11, TP53
CancerNext-Expanded ^{®i,††} (77 genes)	8874	AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, CTNNA1, DICER1, EGFR, EGLN1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD51C, RAD51D, RB1, RECQL, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
ColoNext [®] (20 genes)	8822	APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
CustomNext-Cancer ^{®i,††} (up to 91 genes) Required: complete CustomNext-Cancer supplemental form. ambrygen.com/forms	9510	ABRAXAS1 (FAM175A) [§] , AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CFTR, CHEK2, CPA1, CTNNA1, CTRC, DICER1, EGFR, EGLN1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MLH3 [§] , MRE11A [§] , MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PALLD [§] , PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PRSS1, PTCH1, PTEN, RAD50 [§] , RAD51C, RAD51D, RB1, RECQL, RET, RINT1 [§] , RPS20 [§] , SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERT [§] , TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
HBOC	8838	BRCA1, BRCA2
Lynch syndrome/HNPCC	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup
MelanomaNext [®] (9 genes)	8849	BAP1, BRCA2, CDK4, CDKN2A, MIF, POT1, PTEN, RB1, TP53
PancNext [®] (13 genes)	8042	APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
Pancreatitis panel (6 genes)	8022	CASR, CFTR, CPA1, PRSS1, SPINK1, CTRC
PGLNext [®] (14 genes)	5504	EGLN1, FH, KIF1B, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
ProstateNext ^{®i} (14 genes)	8845	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53
RenalNext [®] (20 genes)	5900	BAP1, CHEK2, EPCAM, FH, FLCN, MET, MIF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL

Genes Eligible for +RNAinsight[®]: APC, ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, NF1, PALB2, PMS2 EX1-10, PTEN, RAD51C, RAD51D, TP53

† AmbryScore for Breast is available as an add on to this panel if all of the following eligibility criteria are met:

- Female biological sex
- 18-84 years old
- Non-Ashkenazi Jewish, N. European ancestry
- No personal history of cancer (excluding non-melanoma skin cancer)
- No personal history of atypical hyperplasia or lobular carcinoma in situ (LCIS)
- No personal or family history of a mutation in a breast cancer susceptibility gene (ATM, BARD1, BLM [if tested], BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FANCC [if tested], NBN, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53)

Note: AmbryScore supplemental ordering form is required for processing

†† AmbryScore for Prostate is available as an add on to this panel if all of the following eligibility criteria are met:

- Male biological sex
- 18-84 years old
- N. European ancestry
- No personal or family history of a mutation in a prostate cancer susceptibility gene (ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53)

Note: No additional ordering forms are required for processing

§ Limited evidence gene