

AmbryScore™ SUPPLEMENTAL ORDERING FORM

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	DOB (MM/DD/YY)

OPT-IN TO AMBRYSCORE

Add AmbryScore to multigene panel testing*

* AmbryScore can only be added to orders for *BRCANext™*, *BRCANext-Expanded™*, *CancerNext®*, *CancerNext-Expanded®*, and *CustomNext-Cancer®*

Eligibility Criteria

I confirm that my patient meets all of the below eligibility criteria for AmbryScore.
Note: If this box is not checked, AmbryScore will not be calculated.

- Non-Ashkenazi Jewish, N. European ancestry
- Female biological sex
- Age 18-84 years
- No personal history of cancer (excluding non-melanoma skin cancer), atypical hyperplasia, or LCIS
- No family history of a mutation in a breast cancer susceptibility gene^

^Breast cancer genes: ATM, BARD1 (if tested), BLM (if tested), BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FANCC (if tested), NBN, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53

BREAST CANCER RISK MODEL INFORMATION (Required for AmbryScore calculation)

Additional Patient Information

Height: ___ft ___in Weight: _____ lbs

Age at first menstruation: _____

Menopausal Status: Pre-menopausal Peri-menopausal Post-menopausal Age of menopause onset (if applicable): _____

Number of live births: _____ Age at first child's birth (if applicable): _____

Has the patient ever used Hormone Replacement Therapy (HRT)? No Yes

If yes, treatment type: Combined Estrogen only

If yes, select one of the following:

Currently using HRT, started _____ years ago; intended to use for _____ more years

Past HRT user, stopped _____ years ago; used for _____ years

Biopsy History:

No prior biopsy No proliferative disease Prior biopsy, result unknown Hyperplasia (not atypical)

Atypical hyperplasia Lobular carcinoma in situ (LCIS)

Mammographic Density:

Has the patient had her breast density assessed? No Yes

If yes, complete one of the following:

Volpara® Volumetric Density: _____%

VAS Percentage Density: _____%

BI-RADS® ATLAS Density (select one of the following):

Almost entirely fatty Scattered fibroglandular density Heterogeneously dense Extremely dense Unknown

Female Relatives

Number of daughters: _____ Number of sisters: _____

Number of maternal aunts (mother's sisters): _____ Number of paternal aunts (father's sisters): _____

Additional family history information provided in the test requisition form and/or any chart notes/pedigrees will also be incorporated into the AmbryScore calculation.