

**COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS**

 To submit an order via email, please send the completed test requisition form to [info@ambrygen.com](mailto:info@ambrygen.com)

PATIENT INFORMATION				
Name (Last, First, MI)		Sex at Birth <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"/> White <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		Preferred Billing <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	

SPECIMEN INFORMATION		
Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Other:		
Collection Date	Specimen ID	Medical Record #

ORDERING LICENSED PROVIDER/SENDING FACILITY			
Facility Name (Facility Code)		Address	
Address (continued)			
Ordering Licensed Provider Name (Last, First)(Code)	Phone	Fax	Email

Additional Results Recipients	
Genetic Counsellor 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. Furthermore, all information on this TRF is true to the best of my knowledge.

<i>Signature Required for Processing</i> Medical Professional Signature:	Date:
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<input type="checkbox"/> INSTITUTIONAL BILLING (to be completed by institution or health authority providing payment)		
Facility Name	Address (with country)	
Contact Name	Phone Number	E-mail/Fax

<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit card (Call +1 949-900-5794)	
Additional billing comments or other order #s (i.e. POs)	
<input type="checkbox"/> Special Billing Notes:	
<b>Patient Acknowledgement:</b> I acknowledge that the information provided by me is true and correct. I understand that my medical data will be transferred to the USA and I authorize such transfer. <b>For patient payment by credit card:</b> I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. 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.	
<i>Signature Required for Self-Pay Patients and Research Consent Patient or Legal Guardian Signature:</i>	Date:

## International Test Requisition Form - Page 1 of 2

**CLINICAL HISTORY**
**PLEASE ATTACH PEDIGREE /CLINICAL CONSULTATION NOTES, IF AVAILABLE**

<b>Cardiac History</b> <input type="checkbox"/> Not Applicable	<b>Other Clinical History</b>
Sudden cardiac arrest <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ # Episodes: _____ Age first incident: _____ Syncope <input type="checkbox"/> Y <input type="checkbox"/> N If yes, # Episodes: _____ Age first incident: _____ History of cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> HCM <input type="checkbox"/> DCM <input type="checkbox"/> ARVC <input type="checkbox"/> LVNC <input type="checkbox"/> RCM <input type="checkbox"/> Other cardiomyopathy types: _____ History of Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> Long QT <input type="checkbox"/> Short QT <input type="checkbox"/> Brugada <input type="checkbox"/> CPVT <input type="checkbox"/> ARVC <input type="checkbox"/> Other arrhythmia types: _____	

**Cancer History**

Cancer/Tumor	Age at Dx	Pathology and Other Info	Metastatic
Breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	<input type="checkbox"/> Yes <input type="checkbox"/> No
2nd primary breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colorectal		Location: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ovarian		<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate		Gleason Score: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uterine			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Cancer		Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
GI polyps		<input type="checkbox"/> Adenomatous Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+ <input type="checkbox"/> Other type: _____ Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+	<input type="checkbox"/> Yes <input type="checkbox"/> No

*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](http://ambrygen.com/specimen-requirements) for details.*

**FAMILY HISTORY**

Relation to patient	Maternal	Paternal	Disease	Dx age
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

**CANCER**

Multi-Gene Testing					
<input type="checkbox"/>	BRCAplus®	8836	8 gene breast cancer test	<input type="checkbox"/>	CancerNext-Expanded® 8874 77 gene cancer test
<input type="checkbox"/>	BRCANext™	8855	18 gene breast and gynecologic cancer test	<input type="checkbox"/>	ColoNext® 8822 20 gene colorectal cancer test
<input type="checkbox"/>	BRCANext-Expanded™	8860	23 genes breast and gynecologic cancer test	<input type="checkbox"/>	ProstateNext® 8845 14 gene prostate cancer test
<input type="checkbox"/>	CancerNext®	8824	36 gene cancer test	<input type="checkbox"/>	Other (Test Code, Test Name)

**CARDIOLOGY**

Check to order	Test Name	Test Code	Description	Check to order	Test Name	Test Code	Description
Comprehensive Cardiovascular Panels				Cardiomyopathy Panels (Cont.)			
<input type="checkbox"/>	CardioNext®	8911	92 genes for hereditary cardiomyopathies and arrhythmias	<input type="checkbox"/>	CMNext®	8887	56 genes for hereditary cardiomyopathy
Arrhythmia, Long QT, and Brugada Panels				Familial Hypercholesterolemia			
<input type="checkbox"/>	RhythmNext®	8900	42 genes for inherited arrhythmias	<input type="checkbox"/>	FHNNext®	8680	4 genes (APOB, LDLR, LDLRAP1, PCSK9)
Cardiomyopathy Panels				<input type="checkbox"/> Check this box if you would like to have the <i>SLC01B1</i> c.521T>C polymorphism reported, which has been associated in medical literature with statin-induced myopathies			
<input type="checkbox"/>	HCMNext®	8936	30 genes for hypertrophic cardiomyopathy				
<input type="checkbox"/>	DCMNext®	8884	37 genes for dilated cardiomyopathy				

**OTHER TESTS**

<input type="checkbox"/> Test Name: _____	Test Code: _____
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## International TRF - Hereditary Cancer Testing 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® (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® (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® (up to 91 genes) Required: complete CustomNext-Cancer supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>	9510	AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CFTR, CHEK2, CPA1, CTNNA1, CTSC, DICER1, EGFR, EGLN1, EPCAM, FAM175A (ABRAXAS1)*, 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, CTSC
PGLNext® (14 genes)	5504	EGLN1, FH, KIF1B, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
ProstateNext® (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

\* Limited evidence gene