

To submit an order via email, please send the completed test requisition form to [info@ambrygen.com](mailto:info@ambrygen.com)
**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)		Sex at Birth <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)
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"/> Native American <input type="checkbox"/> Other:			MRN
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 #
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\* 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

Phlebotomy Services Request:  Phlebotomy draw    Insurance preverification first    Send blood kit to patient\*\*    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.

<b>Signature Required for Processing</b> Medical Professional Signature:	Date:
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<input 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
<b>Out of Pocket:</b> We will start testing immediately and we will attempt to contact the patient if the estimated out-of-pocket costs are > USD \$100.		Contact Name	
Special Billing Notes:		Phone Number	E-mail/Fax
		<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".

<b>Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:</b>	Date:
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## 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).

CANCER TEST ORDERS			
<b>REQUIRED: Select a Primary Test Order</b>		<b>Select an Optional Supplemental Test</b> (Per payer policy, all tests in this section will be processed and billed separately; tests may be performed as a reflex.)	
For Patients Meeting <i>BRCA1/2</i> Testing Criteria		<input type="checkbox"/>	BrainTumorNext® 8847 29 gene brain tumor test
<input type="checkbox"/> <i>BRCA1/2</i> test		<input type="checkbox"/>	BRCANext™ 8855 18 gene breast cancer test
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)		<input type="checkbox"/>	BRCANext-Expanded™ 8860 23 gene breast cancer test
Lynch Syndrome test: <input type="checkbox"/> <i>MLH1, MSH2, MSH6, PMS2, EPCAM</i>		<input type="checkbox"/>	BRCaPlus® 8836 8 gene breast cancer test
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)		<input type="checkbox"/>	CancerNext® 8824 36 gene cancer test
Polyposis test: <input type="checkbox"/> <i>APC/MUYTH</i>		<input type="checkbox"/>	CancerNext-Expanded® 8874 77 gene cancer test
<input type="checkbox"/> Other: _____		<input type="checkbox"/>	ColoNext® 8822 20 gene colorectal cancer test
<input type="checkbox"/> None of the above (patient does not meet any genetic testing criteria)		<input type="checkbox"/>	CustomNext-Cancer® 9510 up to 91 gene custom test ^^
<b>Other Supplemental Test Options (Select if applicable)</b>		<input type="checkbox"/>	MelanomaNext® 8849 9 gene melanoma test
<input type="checkbox"/> +RNAinsight® (Not available with BRCaPlus, pancreatitis panel, or STAT orders; PAXgene® tube required for RNA)		<input type="checkbox"/>	PancNext® 8042 13 gene pancreatic cancer test
<input type="checkbox"/> AmbryScore-Breast (Additional Supplemental Ordering Form REQUIRED)		<input type="checkbox"/>	Pancreatitis panel 8022 6 gene pancreatitis test
<input type="checkbox"/> AmbryScore-Prostate		<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

  

Check to order	Test Name	Test Code	Description
Hereditary Breast and/or Ovarian Cancer			
<input type="checkbox"/>	<i>ATM</i>	9014	Ataxia-telangiectasia
<input type="checkbox"/>	<i>BRCA1/2</i>	8838	Hereditary breast and ovarian cancer
<input type="checkbox"/>	<i>BRCA1/2</i> Ashkenazi Jewish 3-site mutation panel	5892	
<input type="checkbox"/>	<i>CHEK2</i>	9016	
<input type="checkbox"/>	<i>DICER1</i>	5260	
<input type="checkbox"/>	<i>PALB2</i>	2366	
<input type="checkbox"/>	<i>PTEN</i>	2106	<i>PTEN</i> -related disorders (including Cowden syndrome)
<input type="checkbox"/>	<i>TP53</i>	2866	Li-Fraumeni syndrome
Gastrointestinal Cancer			
<input type="checkbox"/>	<i>APC</i>	3040	Familial adenomatous polyposis
<input type="checkbox"/>	<i>APC</i> and <i>MUTYH</i>	8726	Adenomatous polyposis
<input type="checkbox"/>	<i>BMPR1A</i> and <i>SMAD4</i>	8604	Juvenile polyposis syndrome
<input type="checkbox"/>	<i>CDH1</i>	4726	Hereditary diffuse gastric cancer
<input type="checkbox"/>	<i>EPCAM</i> del/dup	8519	Lynch syndrome
<input type="checkbox"/>	Lynch syndrome	8517	<i>MLH1, MSH2, MSH6, PMS2</i> + <i>EPCAM</i> del/dup
<input type="checkbox"/>	<i>MLH1</i>	8508	Lynch syndrome
<input type="checkbox"/>	<i>MSH2</i> + <i>EPCAM</i> del/dup	8510	Includes <i>MSH2</i> inversion
<input type="checkbox"/>	<i>MSH2</i> inversion	2226	Lynch syndrome
<input type="checkbox"/>	<i>MSH6</i>	8512	Lynch syndrome
<input type="checkbox"/>	<i>MUTYH</i>	4661	<i>MUTYH</i> -associated polyposis
<input type="checkbox"/>	<i>PMS2</i>	4646	Lynch syndrome
<input type="checkbox"/>	<i>STK11</i>	2766	Peutz-Jeghers syndrome

  

Check to order	Test Name	Test Code	Description
Genitourinary Cancer			
<input type="checkbox"/>	<i>BAP1</i>	9044	
<input type="checkbox"/>	<i>FH</i>	6301	Hereditary leiomyomatosis and renal cell cancer
<input type="checkbox"/>	<i>FLCN</i>	5921	Birt-Hogg-Dubé syndrome
<input type="checkbox"/>	<i>VHL</i>	2606	Von-Hippel Lindau disease
<input type="checkbox"/>	<i>TSC1</i> and <i>TSC2</i>	5904	Tuberous sclerosis complex
Endocrine Tumors			
<input type="checkbox"/>	<i>MEN1</i>	2646	Multiple endocrine neoplasia type 1
<input type="checkbox"/>	<i>RET</i> gene sequence	2680	Multiple endocrine neoplasia type 2
Skin Cancer/Melanoma			
<input type="checkbox"/>	<i>CDKN2A</i> and <i>CDK4</i> concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
<input type="checkbox"/>	<i>PTCH1</i>	5684	Gorlin syndrome
Other Hereditary Cancer Testing			
<input type="checkbox"/>	<i>NF1</i>	5704	Neurofibromatosis type 1
<input type="checkbox"/>	<i>NF2</i>	9024	Neurofibromatosis type 2
<input type="checkbox"/>	<i>RB1</i>	5426	Hereditary retinoblastoma
<input type="checkbox"/>	<i>SMARCB1</i>	7180	Schwannomatosis
Other Orders			
<input type="checkbox"/>	Please visit <a href="http://ambrygen.com">ambrygen.com</a> for a list of available tests.		
	Test Code(s): _____ Gene/Test Name(s): _____		
<b>SPECIFIC SITE ANALYSIS</b> (Please include a copy of relative's report)			
Gene(s): _____ Mutation(s): _____			
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™ <sup>1</sup> (18 genes)	8855	ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53
BRCANext-Expanded™ <sup>1</sup> (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® <sup>i,††</sup> (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® <sup>i,††</sup> (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® <sup>i,††</sup> (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) <sup>§</sup> , FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MLH3 <sup>§</sup> , MRE11A <sup>§</sup> , MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PALLD <sup>§</sup> , PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PRSS1, PTCH1, PTEN, RAD50 <sup>§</sup> , RAD51C, RAD51D, RB1, RECQL, RET, RINT1 <sup>§</sup> , RPS20 <sup>§</sup> , SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERT <sup>§</sup> , 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® <sup>i</sup> (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 [if tested], 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