

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

Project code: PHRPTC-150300

To submit an order via email, please send the completed test requisition form to 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)					
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish <input type="checkbox"/> Other:					
Address		City		State Zip	
Phone		Email			
SPECIMEN INFORMATION*					
<input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Send saliva kit to patient** <input type="checkbox"/> Phlebotomy request^			<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.					
** 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 and Canadian 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.					
Billing Facility PTC Therapeutics (31786) Attn: Accounts Payable 100 Corporate Court, South Plainfield, NJ 07080					
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	Fax/Email	
Additional Results Recipients					
Genetic Counselor or Other Medical Provider Name (Last, First) (Code)			Phone/Fax/Email		
PATIENT ELIGIBILITY Both suspected early onset hypotonia AND at least one of the following movement disorders must be observed in the patient.					
Inclusion Criteria (Please check all conditions that apply and indicate symptom age of onset)			Additional Symptoms (Please check all that apply and indicate a symptom age of onset)		
Check if Applicable	Clinical Symptom	Age of Onset	Check if Applicable	Clinical Symptom	Age of Onset
Suspected Early Onset Hypotonia			<input type="checkbox"/> Developmental Delay (motor, cognitive, or speech impairment)		
<input type="checkbox"/>	Suspected Early Onset Hypotonia		<input type="checkbox"/>	Autonomic Dysfunction	
Movement Disorders			<input type="checkbox"/>	Gastrointestinal Issues	
<input type="checkbox"/>	Dystonia (facial, torso, or limb)		<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Dyskinesia (hyperkinesia, chorea, athetosis)		<input type="checkbox"/>	Sleep Disturbances	
<input type="checkbox"/>	Oculogyric crises/paroxysmal movements		<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Hypokinesia or bradykinesia		_____		
<input type="checkbox"/>	Myoclonus		_____		
<input type="checkbox"/>	Tremor				
Check to Order	Test Name	Test Code	# of Genes	Gene List	
<input type="checkbox"/>	Movement Disorders + Hypotonia Panel	6867	81	AARS, ABAT, ADCYS, ALDH5A1, ALDH7A1, AMT, AP1S2, ARHGEF9, ATP1A2, ATP1A3, ATP7B, BCKDHA, BCKDHB, COASY, DBT, DDC, DDX3X, DLD, DNAJC12, DNMI, EIF2AK2, ELP2, GAMT, GCDH, GCH1, GLDC, GLRA1, GLRB, GNAO1, GNB1, HPRT1, KCNB1, KCNMA1, KMT2B, MECP, MYBPC1, NBEA, NGLY1, NTNG2, PANK2, PCCA, PCCB, PDE10A, PGAP1, PLA2G6, PNKD, PNPO, PNPT1, PRRT2, PTS, QDPR, RHOBTB2, SCN2A, SCN8A, SERAC1, SGCE, SLC16A2, SLC17A5, SLC18A2, SLC2A1, SLC30A10, SLC39A14, SLC6A3, SLC6A5, SLC6A8, SLC9A6, SPR, SYT1, TET3, TH, TNFR, TOR1A, TUBB4A, UBTF, VAC14, VAMP2, VPS13D, WARS2, WDR45, WDR73, YIF1B	
<input type="checkbox"/>	Reflex to NeurodevelopmentNext-Expanded™	6860	>1400	Not included in sponsored program - must submit insurance or patient self-pay information; Ambry representative will reach out to discuss options	
<input type="checkbox"/>	Reflex to ExomeNext®	(Multiple options)	~20,000	Not included in sponsored program - must submit insurance or patient self-pay information; Ambry representative will reach out to discuss options	
CONFIRMATION OF MEDICAL NECESSITY AND INFORMED CONSENT FOR SPONSORED GENETIC TESTING					
By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Ambry Genetics' Informed Consent for Genetic Testing and in connection with the Program, and has been informed that Ambry Genetics may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated). The medical professional warrants that he/she will not seek reimbursement for this no-charge test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third parties, including commercial organizations, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that de-identified Patient data may be used and shared with such third parties, for purposes which include contacting their medical professional directly in connection with the Program. A list of third party partners may be provided upon request. I attest that I am authorized under applicable state law to order this test. PTC Therapeutics, and the company or companies that help PTC Therapeutics administer the services, request and receive anonymized data (not personally identifiable data) and the results related to the testing necessary to complete publications and/or retrospective reviews for the purposes of publishing studies, including entering and maintaining anonymized health information in a database. Patient identifiers are known only to the requesting physician/institution.					
Signature Required for Processing Medical Professional Signature:				Date:	