

**COMPLETE TO SUBMIT FAMILY MEMBERS FOR EXOME ORDERS**

All family member specimens must be received within 4 weeks of order to be included in analysis

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"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> French Canadian/Cajun <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mediterranean <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Portuguese <input type="checkbox"/> Unknown <input type="checkbox"/> Other:						
Address		City	State	Zip		
Phone	Email		Preferred Billing <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional			
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, Source: <input type="checkbox"/> Other:						
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant*		<input type="checkbox"/> Current diagnosis of heme malignancy, Type*:				
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. See <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> 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.						
CLINICAL INFORMATION						
Is family member affected with the same phenotype as the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly, describe: _____						
TEST MENU						
<input type="checkbox"/> 9993-9996 Family member for ExomeNext® (no charge)		<input type="checkbox"/> 9500 Family member for ExomeNext-Select (no charge)		Proband Name: _____		
<input type="checkbox"/> 9999R Family member for ExomeNext-Rapid® (no charge)		<input type="checkbox"/> Other _____ (Test Code/Test Name)		Relationship to proband: _____		
SECONDARY FINDINGS						
Secondary findings results are available for each family member sequenced as part of the trio.						
Check below to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported. Secondary findings are not available for ExomeNext-Select orders.						
<input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.						
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			
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. 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:			
<b>Family Member Acknowledgement:</b> I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the whole-exome sequencing process prior to testing, and I would like to proceed with test processing. I understand that the primary exome testing is being performed in order to assist analysis for my family member (proband), that a primary report will only be generated for the proband, and that it may be possible to infer information about my results based on the proband's report.						
<b>For NY Residents:</b> <input type="checkbox"/> 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".						
If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.						
Family Member/Guardian Signature: _____			Date: _____			
For all exome orders, Ambry includes testing for co-segregation analysis (aka: family testing for candidate alterations) if samples are sent before testing begins.						