

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

1. Clinic Notes 2. Pedigree 3. Insurance Card

COLLECTION DATE (REQUIRED)

If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)

2. PATIENT INFORMATION

Legal Name (Last, First, MI) _____ Date of Birth (MM/DD/YY) _____ Sex Assigned at Birth F M Gender (optional) Man Woman Nonbinary Self-described

Genetic Ancestry: Ashkenazi Jewish Asian Black/African American French Canadian/Cajun Hispanic/Latino Mediterranean Middle Eastern Native American Pacific Islander Portuguese White Unknown Other: _____ MRN _____

Address _____ City _____ State _____ Zip _____

Mobile # _____ Email _____

SPECIMEN INFORMATION (Please see ambrygen.com/specimen-requirements for details)

Personal history of allogenic bone marrow or peripheral stem cell transplant

Specimen ID _____ Medical Record # _____

Collection Assistance: Phlebotomy draw* Send saliva kit to patient Send buccal kit to patient | Insurance preverification first (available for ExomeNext and SNP array 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.

INDICATION(S) FOR TESTING

ICD-10 code(s): _____ Will medical management change depending upon the results of the test? Yes No

PATIENT HISTORY No personal history of neurological disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date: _____ Upcoming procedure date: _____

Reasons for Testing:

Birth and Neonatal History N/A
 Gestational age at birth: _____ Birth weight: _____
 Head circumference at birth (if available): _____

Developmental History N/A
 Developmental delay: Yes No Unknown
 Type of delay (choose all that apply): Motor Language Global
 Intellectual disability: Yes No Unknown
 Regression or plateau: Yes No Unknown
 Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder? Yes No

Seizure History N/A Age at first unprovoked seizure: _____
 Has this patient been diagnosed with an epilepsy syndrome? Yes No Unknown
 If yes, please specify: _____

Other History N/A
 Hypo-/hyperpigmentation: Yes No Telangiectasias: Yes No
 Other skin abnormality, type: _____
 Brain tumor, type: _____ Nerve tumor, type: _____
 Other tumor, type: _____

Other Clinical Findings (choose all that apply)
 Ataxia Macrocephaly Psychiatric disorder
 Dysmorphic features Microcephaly Spasticity
 Hearing disorder Migraine Vision disorder
 Hypotonia Movement disorder
 Prior Testing: _____

Known Familial Variant: Family Self Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____

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 _____

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.

Signature Required for Processing Medical Professional Signature: _____ Date: _____

INSURANCE BILLING (Include copy of both sides of insurance card) **INSTITUTIONAL BILLING**

Patient Relation to Policy Holder? Self Spouse Child Name and DOB of Policy Holder (if not self) _____ Facility Name _____ Send invoice to facility address above

Insurance Company _____ Policy # _____ HMO Auth # _____ Address _____

Special Billing Notes: _____ Contact Name _____
 Phone Number _____ E-mail/Fax _____

PATIENT PAYMENT Check (Payable to Ambry Genetics)
 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.

I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at <https://www.ambrygen.com/legal/notice-of-privacy-practices>.

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: By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Patient Signature _____ Date: _____

Neurology Test Requisition Form

For Reflex or Concurrent Testing:

 Test 1: _____ Reflex to _____ Test 2: _____ Reflex to _____ Test 3: _____
 Concurrent with _____ Concurrent with _____

See Reflex or Concurrent Testing section of the Supplemental Information page.

Check	Test Name	Test Code	Description	Check	Test Name	Test Code	Description
Exome				Epilepsy			
! REQUIRED: Select a Primary Test Order				<input type="checkbox"/>	EpilepsyNext®	6864	124 genes for epilepsy
<input type="checkbox"/>	ExomeNext®-Trio	9995	Trio exome sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	<input type="checkbox"/>	EpilepsyNext-Expanded™	6865	>950 genes associated with seizures, primarily with neonatal to childhood onset
ExomeNext Supplemental Test Options				Neurodevelopmental Disorders			
<input type="checkbox"/>	ExomeNext®-Trio plus mtDNA	9996	Trio exome sequencing plus mtDNA sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	<input type="checkbox"/>	AutismNext®	6863	72 genes for non-syndromic autism spectrum disorders and/or intellectual disability
<input type="checkbox"/>	ExomeNext®-Duo	9991	Duo exome sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	<input type="checkbox"/>	Autism, macrocephaly	2106	PTEN
<input type="checkbox"/>	ExomeNext®-Duo plus mtDNA	9992	Duo exome sequencing plus mtDNA sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	<input type="checkbox"/>	NeurodevelopmentNext™	6861	202 genes known to cause developmental delay, intellectual disability, and/or autism spectrum disorders
<input type="checkbox"/>	ExomeNext®-Proband	9993	Proband only exome sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	Hereditary Neuropathy			
<input type="checkbox"/>	ExomeNext®-Proband plus mtDNA	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	<input type="checkbox"/>	Familial transthyretin amyloidosis	1560	TTR
<input type="checkbox"/>	ExomeNext®-Rapid® (Institutional billing or patient payment only)	9999R	Rapid Trio exome sequencing plus mtDNA sequencing Secondary Findings*: <input type="checkbox"/> Opt-out	Neurocutaneous/Neuro-Oncology Disorders			
ExomeReveal™				Testing is available for Neurocutaneous and Neuro-Oncology disorders (such as neurofibromatosis and tuberous sclerosis) using our Cancer or Comprehensive requisition forms available at: www.ambrygen.com/providers/forms			
<input type="checkbox"/>	ExomeReveal™	9990	RNA analysis available with all ExomeNext orders except for ExomeNext-Rapid, EDTA and PAXgene RNA tubes required	SINGLE SITE ANALYSIS (Please include a copy of relative's report)			
Fragile X syndrome and Chromosomal Microarray				Gene(s): _____ Mutation(s): _____			
<input type="checkbox"/>	Fragile X syndrome	4544	FMR1 repeat expansion analysis and methylation studies	Relative Name: _____			
<input type="checkbox"/>	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)	Relationship to Relative: _____ Accession # (If tested at Ambry): _____			
<input type="checkbox"/>	Familial targeted microarray	5495	Paid option. Only available following SNP Array (5490) completed at Ambry. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambry: _____	Positive control sample: <input type="checkbox"/> Will be provided <input type="checkbox"/> Already at Ambry <input type="checkbox"/> Not available			
				FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED			
				Both test codes required for fetal specimens.			
				<input type="checkbox"/>	1260	MCC for fetal specimen or cord blood	
				<input type="checkbox"/>	1262	MCC Reference for maternal blood sample (No Charge)	

* Secondary Findings: If box is left unchecked, the ACMG recommended list of Secondary Findings will be reported.

 Opt-in to Reporting of Variants of Unknown Significance (VUS)

For patients undergoing an epilepsy or neurodevelopmental disorder panel, checking this box indicates that VUS identified on the test(s) ordered above will be reported for this patient. If you do not check this box, VUS will not be reported.

 Parental samples provided for cosegregation

Cosegregation testing of family members is available for the following panels: EpilepsyNext, EpilepsyNext-Expanded, AutismNext, NeurodevelopmentNext

FAMILY MEMBER INFORMATION (Completion of this section is required for order including parental samples. If available, please also submit a 3-generation pedigree)

Relative	Name	DOB	Affected status**	Samples included?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

** If affected, please list symptoms and age at diagnosis:

Neurology Test Requisition Form

PROBAND'S CLINICAL OVERVIEW (Check yes for all that apply)		
<input type="checkbox"/> Yes <input type="checkbox"/> No Audiologic/Otolaryngologic <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No Craniofacial <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Dysmorphic Features <input type="checkbox"/> Yes <input type="checkbox"/> No Dermatologic <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No Fetal (Please complete and attach "ExomeNext Prenatal Form") <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No Genitourinary <input type="checkbox"/> Yes <input type="checkbox"/> No Growth Disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No Undergrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Overgrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Failure to thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No Hematologic <input type="checkbox"/> Yes <input type="checkbox"/> No Immunologic/Infectious/Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Metabolic/Biochemical <input type="checkbox"/> Yes <input type="checkbox"/> No Movement Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Musculoskeletal/Structural <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Congenital Anomalies <input type="checkbox"/> Yes <input type="checkbox"/> No Neurologic <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autism Spectrum Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental Delay/Intellectual disability <input type="checkbox"/> Yes <input type="checkbox"/> No Ataxia/Spasticity <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal brain MRI <input type="checkbox"/> Yes <input type="checkbox"/> No Obstetric <input type="checkbox"/> Yes <input type="checkbox"/> No Oncologic	<input type="checkbox"/> Yes <input type="checkbox"/> No Ophthalmologic <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary <input type="checkbox"/> Yes <input type="checkbox"/> No Renal <input type="checkbox"/> Yes <input type="checkbox"/> No Tone abnormalities <input type="checkbox"/> Yes <input type="checkbox"/> No Hypotonia <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertonia

Supplemental Information

Sample Requirements

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.

Buccal swab samples from patients with a history of allogenic bone marrow or stem cell transplant should not be used for genetic testing. For these patients, an alternative specimen (e.g. cultured fibroblasts) is required. Testing on buccal swab samples from patients with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended. Please see ambrygen.com/specimen-requirements for details.

Fetal specimens, cord blood and POC will have maternal cell contamination (MCC) studies added for a charge. Maternal and fetal specimen required. Please see page 2 for MCC test codes.

Specific site analysis for variants identified at an external laboratory must be accompanied by a copy of the original testing report. A positive control from a known positive family member is recommended (required for prenatal testing).

Reflex or Concurrent Testing

Concurrent testing is when multiple tests are initiated at the same time. When multiple tests are ordered on the same test requisition form, testing will be run concurrently unless otherwise specified.

Reflex testing is when a subsequent test is initiated pending the outcome of the initial test. Reflex testing may result in delayed reporting of results.

For reflex test orders:

- Any diagnostic finding at any step will result in cancellation of any subsequent reflex tests.
- Non-diagnostic findings (including VUS or Uncertain results) will automatically reflex to the subsequent test.
- Secondary findings results do not impact whether a subsequent test is initiated or canceled.

ExomeNext Medical Necessity Form

REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is ONLY required if you are requesting reflex to Exome sequencing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

- Yes, date performed: _____
 No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

- Multiple abnormalities affecting unrelated organ systems (please specify): _____
OR two of the following:
 Abnormality affecting a single organ system(specify): _____
 Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)
 Family history strongly implicating a genetic etiology (please specify findings and relationships)
 Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

- Yes (please describe): _____
 No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

- Chromosomal microarray
 Single gene test(s): _____
 Multigene panel(s): _____
 Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

- Imaging study: _____
 Surgery: _____
 Biopsy: _____
 Other: _____