

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

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 <input type="checkbox"/> Cord Blood** <input type="checkbox"/> Other**:	<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. See ambrygen.com/specimen-requirements for details.
 ** Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see page 2 for Maternal Cell Contamination sample submission test codes.

Phlebotomy Services Request: Phlebotomy draw Send blood kit to patient* Send saliva 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> STAT TEST: Date results needed (if known): _____
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PATIENT HISTORY No personal history of pulmonology disease

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

Reason(s) for Testing		Relevant lab results (include copies if possible)
<input type="checkbox"/> Positive newborn screen <input type="checkbox"/> Infections: _____ <input type="checkbox"/> Sweat chloride: _____mmol/L <input type="checkbox"/> Sweat chloride: <input type="checkbox"/> <40 <input type="checkbox"/> 40-60 <input type="checkbox"/> >60 <input type="checkbox"/> Congenital bilateral absence of the vas deferens <input type="checkbox"/> Meconium ileus <input type="checkbox"/> Pancreatic insufficiency IRT level: _____ <input type="checkbox"/> Respiratory distress, explain: _____ <input type="checkbox"/> Respiratory assistance devices: _____ <input type="checkbox"/> Ultrasound findings: _____ <input type="checkbox"/> Other: _____		FAMILY HISTORY <input type="checkbox"/> None (maternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> None (paternal) <input type="checkbox"/> Paternal hx unknown Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Diagnosis _____ Dx age _____ Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Diagnosis _____ Dx age _____

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 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 Ambyr 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? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name and DOB of Policy Holder (if not self)	HMO Auth #	Facility Name <input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #		Address
Out of Pocket: In many cases, we will start testing immediately (may vary by test or insurance). 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 Ambyr 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 Ambyr Genetics Corporation (Ambyr), authorize Ambyr 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 Ambyr money received from my health insurance company.
For patient payment by credit card: I hereby authorize Ambyr Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambyr'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 Ambyr 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 Ambyr Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

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

Pulmonology Test Requisition Form - Page 2 of 2

Please check the box next to the test(s) being ordered below. If this TRF is sent to Ambyr without or ahead of the sample, it will be treated as a preverification. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample. Preverification will only be performed for ExomeNext or SNP Array testing.

For multiple test orders, testing will be run concurrently (multiple tests initiated at the same time) unless otherwise specified. To order reflexive testing (second test starts pending first test outcome), please clearly 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 out to the clinician, and the requested second test will be canceled; all other findings will automatically reflex (including VUS).

Check to order	Test Name	Test Code	Description
Congenital Central Hypoventilation Syndrome			
<input type="checkbox"/>	Congenital central hypoventilation syndrome	1580	<i>PHOX2B</i> gene sequence
Cystic Fibrosis			
<input type="checkbox"/>	508 FIRST®	1002	<input type="checkbox"/> Report poly T/TG status Test for <i>CFTR</i> deltaF508 mutation with reflex to <i>CFTR</i> gene sequence and deletion/duplication
<input type="checkbox"/>	<i>CFTR</i> gene sequence and deletion/duplication analysis	1007	<input type="checkbox"/> Report poly T/TG status
Primary Ciliary Dyskinesia			
<input type="checkbox"/>	PCDNext®	8122	<input type="checkbox"/> Report poly T/TG status 21 genes for primary ciliary dyskinesia
Pulmonary Fibrosis			
<input type="checkbox"/>	Telomere-related pulmonary fibrosis	8140	<i>TERT, TERC</i>
Respiratory Distress Syndrome			
<input type="checkbox"/>	Surfactant dysfunction panel	8100	<i>ABCA3, SFTPB, SFTPC</i> gene sequence
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)	
SPECIFIC SITE ANALYSIS (Please include a copy of relative's report)			
Gene(s): _____ Mutation(s): _____			
Relative Name: _____			
Relationship to Relative: _____			
Accession # (If tested at Ambyr): _____			
Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambyr <input type="checkbox"/> not available			

Check to order	Test Name	Test Code	Description
Clinical Genomics			
<input type="checkbox"/>	SNP Array^^	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
<input type="checkbox"/>	Familial targeted microarray^^	5495	Paid option. Only available following SNP Array (5490) completed at Ambyr. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambyr: _____
<input type="checkbox"/>	ExomeNext®-Proband	9993	Proband only exome sequencing Secondary Findings†: <input type="checkbox"/> Opt-out
<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"/>	ExomeNext®-Duo	9991	Duo exome sequencing Secondary Findings†: <input type="checkbox"/> Opt-out[See ExomeNext-Trio]
<input type="checkbox"/>	ExomeNext®-Duo plus mtDNA	9992	Duo exome sequencing plus mtDNA sequencing Secondary Findings†: <input type="checkbox"/> Opt-out[See ExomeNext-Trio]
<input type="checkbox"/>	ExomeNext®-Trio	9995	Trio exome sequencing Secondary Findings†: <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext®-Trio plus mtDNA	9996	Trio exome sequencing plus mtDNA sequencing Secondary Findings†: <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext-Rapid®††	9999R	Trio exome sequencing plus mtDNA sequencing Secondary Findings†: <input type="checkbox"/> Opt-out
<input type="checkbox"/>	Order through Ambyr-Port®	9500	Up to 500 gene custom exome sequencing test
^^ Buccal swab accepted for SNP Array † Secondary Findings: If box is left unchecked, the ACMG recommended list of secondary findings will be reported. Secondary findings are not available for ExomeNext-Select orders. †† Institutional billing or patient payment only			