

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

To submit an order via email, please send the completed test requisition form to [info@ambrygen.com](mailto:info@ambrygen.com)

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)

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:
1. Clinic Notes    2. Pedigree    3. Insurance Card and Authorization Documents

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		

SPECIMEN INFORMATION (Please see <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details)	
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant	
Specimen ID	Medical Record #
Collection Assistance: <input type="checkbox"/> Phlebotomy draw* <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.	

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 Ambrly 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:
--	-------

<input checked="" 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	Facility Name <input type="checkbox"/> Send invoice to facility address above
Name and DOB of Policy Holder (if not self) Insurance Company      Policy #      HMO Auth #	Address
Special Billing Notes:	Contact Name  Phone Number      E-mail/Fax
<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable to Ambrly 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 Ambrly Genetics Corporation (Ambrly), authorize Ambrly 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 Ambrly money received from my health insurance company.  
**For patient payment by credit card:** I hereby authorize Ambrly Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambrly'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 Ambrly 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 Ambrly 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, Ambrly Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

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

## Cancer Test Requisition Form (Comprehensive)- Page 2 of 3

INDICATIONS FOR TESTING (Check all that apply)					
ICD-10 code(s): _____					
Testing could aid in systemic therapy and/or surgical decision-making for my affected patient <input type="checkbox"/> Yes <input type="checkbox"/> No   <input type="checkbox"/> STAT TEST: Date results needed (if known): _____					
Was genetic counseling completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date Genetic Counseling was Performed: _____					
PATIENT CLINICAL HISTORY					
<input type="checkbox"/> No personal history of cancer					
Cancer/Tumor	Age at Dx	Pathology and Other Info			
Brain tumor					
Breast		Type:	ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N
2nd primary breast		Type:	ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk	HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N
Colorectal		Location:			
Melanoma					
Ovarian		<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal			
Pancreatic					
Prostate		Gleason Score:		Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N	
Uterine					
Hematologic		Type: <input type="checkbox"/> Allogenic bone marrow or peripheral stem cell transplant^			
Other Cancer		Type:			
GI polyps		<input type="checkbox"/> Adenomatous	Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+		
		<input type="checkbox"/> Other type:	Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+		
Other clinical history:					
^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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details					
PATIENT TESTING HISTORY (Please include copies of any previous test results)					
<input type="checkbox"/> No previous molecular and/or genetic testing					
<input type="checkbox"/> Germline genetic testing Test(s) performed: _____ Result (s): _____			<input type="checkbox"/> Microsatellite instability analysis: <input type="checkbox"/> Stable (MSS) <input type="checkbox"/> Unstable/high (MSI-H) <input type="checkbox"/> Unstable/low (MSI-L)		
<input type="checkbox"/> Somatic test/tumor profile Test(s) performed: _____ Result(s): _____			<input type="checkbox"/> IHC, if multiple primaries, tumor used: _____ <input type="checkbox"/> Proteins present: _____ <input type="checkbox"/> Proteins absent: _____		
FAMILY HISTORY					
Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.					
Family History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide relative information below.)				Patient Testing and Cancer Type Details:	
Relationship to Patient	Maternal	Paternal	Age at Each Dx	Family Testing and Cancer Type Details	If Relative Has Not Been Tested, Why? (select option)
	<input type="checkbox"/>	<input type="checkbox"/>		Cancer type(s): Pathology Details: Testing Details:	<input type="checkbox"/> Deceased <input type="checkbox"/> Declines Testing <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>		Cancer type(s): Pathology Details: Testing Details:	<input type="checkbox"/> Deceased <input type="checkbox"/> Declines Testing <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>		Cancer type(s): Pathology Details: Testing Details:	<input type="checkbox"/> Deceased <input type="checkbox"/> Declines Testing <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>		Cancer type(s): Pathology Details: Testing Details:	<input type="checkbox"/> Deceased <input type="checkbox"/> Declines Testing <input type="checkbox"/> No Contact

## 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.)
<b>For Patients Meeting BRCA1/2 Testing Criteria</b> <input type="checkbox"/> BRCA1/2 test	<input type="checkbox"/> BrainTumorNext® 8847 29 gene brain tumor test
<b>For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)</b> Lynch Syndrome test: <input type="checkbox"/> MLH1, MSH2, MSH6, PMS2, EPCAM	<input type="checkbox"/> BRCANext® 8855 18 gene breast cancer test
<b>For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)</b> Polyposis test: <input type="checkbox"/> APC/MUTYH	<input type="checkbox"/> BRCANext-Expanded® 8860 23 gene breast cancer test
<input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above (patient does not meet any genetic testing criteria)	<input type="checkbox"/> BRCAplus® 8836 8 gene breast cancer test
<b>Other Supplemental Test Options (Select if applicable)</b> <input type="checkbox"/> +RNAinsight® (Not available with BRCAplus, pancreatitis panel, or STAT orders; PAXgene® tube required for RNA)	<input type="checkbox"/> CancerNext® 8824 36 gene cancer test
	<input type="checkbox"/> CancerNext-Expanded® 8874 77 gene cancer test
	<input type="checkbox"/> ColoNext® 8822 20 gene colorectal cancer test
	<input type="checkbox"/> CustomNext-Cancer® Notes: _____ _____ _____
	<input type="checkbox"/> MelanomaNext® 8849 9 gene melanoma test
	<input type="checkbox"/> PancNext® 8042 13 gene pancreatic cancer test
	<input type="checkbox"/> Pancreatitis panel 8022 6 gene pancreatitis test
	<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

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

Order	Test Name	Test Code	Description
<b>Genitourinary Cancer</b>			
<input type="checkbox"/>	BAP1	9044	
<input type="checkbox"/>	FH	6301	Hereditary leiomyomatosis and renal cell cancer
<input type="checkbox"/>	FLCN	5921	Birt-Hogg-Dubé syndrome
<input type="checkbox"/>	VHL	2606	Von-Hippel Lindau disease
<input type="checkbox"/>	TSC1 and TSC2	5904	Tuberous sclerosis complex
<b>Endocrine Tumors</b>			
<input type="checkbox"/>	MEN1	2646	Multiple endocrine neoplasia type 1
<input type="checkbox"/>	RET gene sequence	2680	Multiple endocrine neoplasia type 2
<b>Skin Cancer/Melanoma</b>			
<input type="checkbox"/>	CDKN2A and CDK4 concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
<input type="checkbox"/>	PTCH1	5684	Gorlin syndrome
<b>Other Hereditary Cancer Testing</b>			
<input type="checkbox"/>	NF1	5704	Neurofibromatosis type 1
<input type="checkbox"/>	NF2	9024	Neurofibromatosis type 2
<input type="checkbox"/>	RB1	5426	Hereditary retinoblastoma
<input type="checkbox"/>	SMARCB1	7180	Schwannomatosis
<b>Other Orders</b>			
<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): _____		

**SPECIFIC SITE ANALYSIS** (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:  will be provided  already at Ambry  not available

## Supplemental Information

### Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	<i>APC, MUTYH</i>
BrainTumorNext® (29 genes)	8847	<i>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</i>
BRCANext®† (18 genes)	8855	<i>ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53</i>
BRCANext-Expanded® (23 genes)	8860	<i>ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, RECQL, SMARCA4, STK11, TP53</i>
BRCAPlus® (8 genes)	8836	<i>ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53</i>
CancerNext® (36 genes)	8824	<i>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</i>
CancerNext-Expanded® (77 genes)	8874	<i>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</i>
ColoNext® (20 genes)	8822	<i>APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53</i>
CustomNext-Cancer® (up to 91 genes) Required: complete CustomNext-Cancer supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>	9510	<i>AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CFTR, CHEK2, CPA1, CTNNA1, CTRC, DICER1, EGFR, EGLN1, EPCAM, FAM175A(ABRAXAS1)†, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MLH3†, MRE11A†, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PALLD†, PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PRSS1, PTCH1, PTEN, RAD50†, RAD51C, RAD51D, RB1, RECQL, RET, RINT1†, RPS20†, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERT†, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2</i>  For Medicare Patients: At a minimum, the following core genes must be included in the panel to ensure Medicare coverage: <i>APC, ATM, BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, TP53</i> .
HBOC	8838	<i>BRCA1, BRCA2</i>
Lynch syndrome/HNPCC	8517	<i>MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup</i>
MelanomaNext® (9 genes)	8849	<i>BAP1, BRCA2, CDK4, CDKN2A, MIF, POT1, PTEN, RB1, TP53</i>
PancNext® (13 genes)	8042	<i>APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53</i>
Pancreatitis panel (6 genes)	8022	<i>CASR, CFTR, CPA1, PRSS1, SPINK1, CTRC</i>
PGLNext® (14 genes)	5504	<i>EGLN1, FH, KIF1B, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL</i>
ProstateNext® (14 genes)	8845	<i>ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53</i>
RenalNext® (20 genes)	5900	<i>BAP1, CHEK2, EPCAM, FH, FLCN, MET, MIF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL</i>

† Limited evidence gene

### Specimen 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](http://ambrygen.com/specimen-requirements) for details.