

**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)

**PLEASE SUBMIT THE FOLLOWING WITH THE TRF:**

1. Clinic Notes    2. Pedigree    3. Insurance Card

**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

**FAMILY HISTORY\***     None (maternal)     None (paternal)     Maternal hx unknown     Paternal hx unknown

\*Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigrees and other clinical family history notes should be supplied as well when sending in your order.

Relation to patient	Mat	Pat	H/o cardio disease	Dx age	Relation to patient	Mat	Pat	H/o cardio disease	Dx age
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		

**SPECIMEN INFORMATION\*\*** (Please see [ambrygen.com/specimen-requirements](http://ambrygen.com/specimen-requirements) for details)

Personal history of allogenic bone marrow or peripheral stem cell transplant

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)	Specimen ID <input type="checkbox"/> Send saliva kit to patient	Medical Record #
----------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------	------------------

Specimen is post-mortem    Date of death: \_\_\_\_\_    Specimen Type: \_\_\_\_\_

\*\* 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.

Collection Assistance:  Phlebotomy draw\*     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.

**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, 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? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name and DOB of Policy Holder (if not self)	Facility Name <input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #    HMO Auth #	Address

Special Billing Notes:	Contact Name	
	Phone Number	E-mail/Fax
	<input type="checkbox"/> <b>PATIENT PAYMENT</b> <input type="checkbox"/> Check (Payable to Ambry 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 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.  
**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:** \_\_\_\_\_    Date: \_\_\_\_\_

## Cardiovascular Test Requisition Form - Page 2 of 3

INDICATIONS FOR TESTING (Check all that apply)			
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Family history <input type="checkbox"/> Positive or normal control <input type="checkbox"/> Other _____			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): _____			
CLINICAL HISTORY (Please supply clinic notes and pedigree)			
<input type="checkbox"/> No personal history of cardiovascular disease Sudden cardiac arrest <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ Syncope <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ History of cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N    Age at dx: _____ Type(s) of cardiomyopathy: _____ History of Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N    Age at dx: _____		Type(s) of Arrhythmia: _____ <input type="checkbox"/> Clinical diagnosis of Marfan Syndrome or other connective tissue disorder <input type="checkbox"/> Aortic Aneurysm/Dilation    Age at dx: _____ z-score: _____ <input type="checkbox"/> Other Aneurysm Location: _____    Age at dx: _____ <input type="checkbox"/> Aortic/Vascular Dissection Location: _____    Age at dx: _____ <input type="checkbox"/> History of familial hypercholesterolemia <input type="checkbox"/> Other history: _____	
CLINICAL TESTING AND PROCEDURES			
LDL-C: _____ Total Cholesterol: _____ Age at Testing: _____ Procedures (e.g.: EKG, ECHO, etc.)    Age: _____ Result (e.g.: LVIDd, PWd, Qtc, etc.): _____ Type: _____ Cardiovascular Device implant (eg: Pacemaker, ICD, LVAD, etc.):    Age at implantation: _____ Type: _____			
PREVIOUS GENETIC TESTING (Please include copies of any previous test results) <input type="checkbox"/> No previous molecular and/or genetic testing			
Test	Laboratory	Results	
CARDIOVASCULAR TEST OPTIONS			
Check to order	Test Name	Test Code	Description
Cardiomyopathy Panels			
<input type="checkbox"/>	HCMNext®	8936	30 genes for hypertrophic cardiomyopathy
<input type="checkbox"/>	HCMNext Reflex	8883	MYBPC3, MYH7 reflex to HCMNext
<input type="checkbox"/>	DCMNext®	8884	37 genes for dilated cardiomyopathy
<input type="checkbox"/>	CMNext®	8887	56 genes for hereditary cardiomyopathy
<input type="checkbox"/>	ARVCNext®	8904	11 genes for arrhythmogenic right ventricular cardiomyopathy
Arrhythmia Panels			
<input type="checkbox"/>	LongQTNext	8890	17 genes for long QT, Brugada and short QT syndromes
<input type="checkbox"/>	RhythmNext®	8900	42 genes for long QT syndrome, Brugada and short QT syndromes, CPVT and ARVC
<input type="checkbox"/>	CPVTNext®	8902	4 genes for catecholaminergic polymorphic ventricular tachycardia
Aneurysms and Related Disorders			
<input type="checkbox"/>	TAADNext®	8789	35 genes for thoracic aortic aneurysms/dissections, Marfan syndrome, Ehlers-Danlos and related disorders
<input type="checkbox"/>	Marfan reflex to TAADNext	8783	FBN1 reflex to TAADNext
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 Ambry): _____			
Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available			
Comprehensive Cardiovascular Panels			
<input type="checkbox"/>	CardioNext®	8911	92 genes for hereditary cardiomyopathies and arrhythmias
<input type="checkbox"/>	CustomNext-Cardio®	9520	Up to 167 genes related to hereditary cardiomyopathies, arrhythmias, TAAD, HHT, Noonan, and lipidemias. Required: completed CustomNext-Cardio supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>
Familial Hypercholesterolemia and Lipid Disorders			
<input type="checkbox"/>	FHNext®	8680	4 genes (APOB, LDLR, LDLRAP1, PCSK9)
<input type="checkbox"/> Check this box if you would like to have the SLC01B1 c.521T>C polymorphism reported with FHNext, which has been associated in medical literature with statin-induced myopathies			
<input type="checkbox"/>	FCSNext (Familial Chylomicronemia Syndrome)	8920	APOA5, APOC2, GPIIIBP1, LMF1, LPL
<input type="checkbox"/>	Sitosterolemia	8930	ABCG5, ABCG8
Hereditary Hemorrhagic Telangiectasia (HHT)			
<input type="checkbox"/>	HHTNext®	8672	ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4
Noonan Syndrome			
<input type="checkbox"/>	NoonanNext	8402	18 genes for RASopathies
Other			
<input type="checkbox"/>	Transthyretin amyloidosis	1560	TTR
<input type="checkbox"/>	SNP Array***	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
OTHER ORDER			
Test Code: _____ Test Name: _____			

\*\*\* Buccal swab accepted for SNP Array

 For more information visit [ambrygen.com](http://ambrygen.com)

## Supplemental Information

### 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. See [ambrygen.com/specimen-requirements](https://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](https://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.