Ambry Genetics®

Pulmonology Test Requisition Form - Page 1 of 3

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

PATIENT INFORMATION

Name (Last, First, MI)	Sex at Birth ☐F ☐M	Date of Birth (MM/DD/YY)	MRN

Ethnicity: ☐ Asian ☐ Ashkenazi Jewish ☐ Black/African American ☐ White ☐ French Canadian/Cajun ☐ Hispanic/Latino ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Portuguese ☐ Unknown ☐ Other:

Address	City	State	Zip

Phone	Email	Preferred Billing ☐ Insurance ☐ Self-pay ☐ Institutional

SPECIMEN INFORMATION* (Please see 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	Medical Record #

** 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.*

INDICATION(S) FOR TESTING

ICD-10 code(s):

Will medical management change depending upon the results of the test? ☐ Yes ☐ No

☐ STAT TEST: Date results needed (if known):_____

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

☐ Positive newborn screen
☐ Infections: _____
☐ Sweat chloride: _____mmol/L
☐ Sweat chloride: ☐<40 ☐ 40-60 ☐ >60
☐ Congenital bilateral absence of the vas deferens
☐ Meconium ileus
☐ Pancreatic insufficiency IRT level: _____
☐ Respiratory distress, explain: _____
☐ Respiratory assistance devices: _____
☐ Ultrasound findings: _____
☐ Other:_____

Relevant lab results (include copies if possible)

FAMILY HISTORY

☐ None (maternal) ☐ Maternal hx unknown ☐ None (paternal) ☐ Paternal hx unknown

Relationship to patient_____ ☐ Maternal ☐ Paternal

Diagnosis_____ Dx age _____

Relationship to patient_____ ☐ Maternal ☐ 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 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)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Auth #

Special Billing Notes:

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*

Address

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. **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:

Ambry Genetics®

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

1. Clinic Notes 2. Pedigree 3. Insurance Card and Authorization Documents

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Please check the box next to the test(s) being ordered below. If this TRF is sent to Ambry 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			
☐	Congenital central hypoventilation syndrome	1580	*PHOX2B* gene sequence
Cystic Fibrosis			
☐	508 FIRST®	1002	☐ Report poly T/TG status Test for *CFTR* deltaF508 mutation with reflex to *CFTR* gene sequence and deletion/duplication
☐	*CFTR* gene sequence and deletion/duplication analysis	1007	☐ Report poly T/TG status
Primary Ciliary Dyskinesia			
☐	PCDNext®	8122	☐ Report poly T/TG status 21 genes for primary ciliary dyskinesia
Pulmonary Fibrosis			
☐	Telomere-related pulmonary fibrosis	8140	*TERT, TERC*
Respiratory Distress Syndrome			
☐	Surfactant dysfunction panel	8100	*ABCA3, SFTPB, SFTPC* gene sequence

FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQURED.
Both test codes required for fetal specimens

☐ 1260 MCC for fetal specimen or cord blood
☐ 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: ☐ will be provided ☐ already at Ambry ☐ not available

Check to order	Test Name	Test Code	Description
Clinical Genomics			
☐	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
☐	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: _____
☐	ExomeNext®-*Proband*	9993	Proband only exome sequencing Secondary Findings†: ☐ Opt-out
☐	ExomeNext®-*Proband* plus mtDNA	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings†: ☐ Opt-out
☐	ExomeNext®-*Duo*	9991	Duo exome sequencing Secondary Findings†: ☐ Opt-out[See ExomeNext-Trio]
☐	ExomeNext®-*Duo* plus mtDNA	9992	Duo exome sequencing Secondary Findings†: ☐ Opt-out[See ExomeNext-Trio]
☐	ExomeNext®-*Trio*	9995	Trio exome sequencing Secondary Findings†: ☐ Opt-out
☐	ExomeNext®-*Trio* plus mtDNA	9996	Trio exome sequencing plus mtDNA sequencing Secondary Findings†: ☐ Opt-out
☐	ExomeNext-*Rapid*®† †	9999R	Trio exome sequencing plus mtDNA sequencing Secondary Findings†: ☐ Opt-out
Order through Ambry-Port®	ExomeNext®-*Select*	9500	Up to 500 gene custom exome sequencing test

† 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

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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 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.

7 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

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