

**COMPLETE ENTIRE FORM TO AVOID DELAYS**

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

<b>COLLECTION DATE (REQUIRED)</b>					
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)					
<b>PATIENT INFORMATION</b>					
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		
<b>SPECIMEN INFORMATION</b> (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"/> Send saliva kit to patient					
<b>PRENATAL SAMPLES ONLY*</b>					
Sample type: <input type="checkbox"/> Direct CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured amnio <input type="checkbox"/> POC <input type="checkbox"/> Cultured POC			Gestational age at sample collection		
* Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.					
<b>INDICATION(S) FOR TESTING</b>					
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			
<b>ORDERING LICENSED PROVIDER/SENDING FACILITY</b> (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		
<b>ADDITIONAL RESULTS RECIPIENTS</b>					
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			
<b>CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING</b>					
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.					
<b>Signature Required for Processing</b> Medical Professional Signature:			Date:		
<input type="checkbox"/> <b>INSURANCE BILLING</b> (Include copy of both sides of insurance card)		<input type="checkbox"/> <b>INSTITUTIONAL BILLING</b>			
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)			
<b>Patient Acknowledgement:</b> 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. <b>For patient payment by credit card:</b> 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.					
<b>For NY Residents:</b> <input type="checkbox"/> 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.					
<b>Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:</b>			Date:		

## Specific Site Analysis Test Requisition Form - Page 2 of 3

SPECIFIC SITE ANALYSIS (5555)		
Positive control: <input type="checkbox"/> Sent <input type="checkbox"/> To be sent <input type="checkbox"/> Not available <input type="checkbox"/> Available at Ambry, accession #:		
The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory:  1. Proband report (mandatory) 2. Positive control (recommended; required for prenatal testing)  ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence alteration. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.	<b>ALTERATION TO BE TESTED</b>	
	Gene 1	Alteration 1
	Gene 2	Alteration 2
	Gene 3	Alteration 3
	Gene 4	Alteration 4
PATIENT CLINICAL INFORMATION		
<input type="checkbox"/> Healthy <input type="checkbox"/> Affected/Symptomatic, age at diagnosis: _____  Please list relevant clinical findings with ICD-10 codes:		
PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)		
Previously Detected Alteration(s)	Gene Name	Testing Lab
Patient previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No    Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name	Date of Birth (MM/DD/YY)	Relation
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)		

## Supplemental Information - Page 3 of 3

### 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.

Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.