

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

COLLECTION DATE (REQUIRED)
<p>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)</p>

2. PATIENT INFORMATION			
Legal Name (Last, First, MI)	Sex Assigned at Birth <input type="checkbox"/> F <input type="checkbox"/> M	Gender (optional) <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Nonbinary <input type="checkbox"/> Self-described	Date of Birth (MM/DD/YY)
Genetic Ancestry: <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <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"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other:			MRN
Address		City	State Zip
Phone	Email	Preferred Billing <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	

SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements for details)	
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant	<input type="checkbox"/> Current diagnosis of heme malignancy, Type:
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 4 for Maternal Cell Contamination sample submission test codes	
Collection Assistance: <input type="checkbox"/> Phlebotomy draw** <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient <input type="checkbox"/> 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	Fax/Email	

ADDITIONAL RESULTS RECIPIENTS	
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:
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<input 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	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"/> PATIENT PAYMENT <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.
 I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at <https://www.ambrygen.com/legal/notice-of-privacy-practices>.
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.

Patient Signature (I agree to terms above):	Date:
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ONLY COMPLETE FOR EXOMENEXT-DUO/TRIO ORDERS OR IF FAMILY MEMBERS WILL BE SUBMITTED FOR CO-SEGREGATION.
 All family member specimens must be received within 4 weeks of order. Otherwise test will be run as proband only.

FAMILY MEMBER #1 INFORMATION				
Legal Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
Sex Assigned at Birth: <input type="checkbox"/> F <input type="checkbox"/> M	Gender (optional) <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Nonbinary <input type="checkbox"/> Self-described	Genetic Ancestry: <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <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"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State	Zip
				Relationship to proband
SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements for details)				
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant		<input type="checkbox"/> Current diagnosis of heme malignancy, Type:		
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.				
Collection Assistance: <input type="checkbox"/> Phlebotomy draw** <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient <input type="checkbox"/> 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.				

CLINICAL INFORMATION	
Does the family member have any features similar to the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly	
Describe:	
SECONDARY FINDINGS	
Secondary findings results are available for each family member sequenced as part of the trio. Check below to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported.	
<input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.	

FAMILY MEMBER #2 INFORMATION				
Legal Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
Sex Assigned at Birth: <input type="checkbox"/> F <input type="checkbox"/> M	Gender (optional) <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Nonbinary <input type="checkbox"/> Self-described	Genetic Ancestry: <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <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"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State	Zip
				Relationship to proband
SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements for details)				
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant		<input type="checkbox"/> Current diagnosis of heme malignancy, Type:		
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.				
Collection Assistance: <input type="checkbox"/> Phlebotomy draw** <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient <input type="checkbox"/> 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.				

CLINICAL INFORMATION	
Does the family member have any features similar to the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly	
Describe:	
SECONDARY FINDINGS	
Secondary findings results are available for each family member sequenced as part of the trio. Check below to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported.	
<input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.	

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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
PROBAND'S PRIMARY INDICATION FOR TESTING	
Please describe in a few words the main reason for ordering exome testing (<i>Please also provide clinic notes and pedigree</i>):	
PROBAND'S CLINICAL OVERVIEW (Check yes for all that apply)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Audiologic/Otolaryngologic <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No Craniofacial <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Dysmorphic Features <input type="checkbox"/> Yes <input type="checkbox"/> No Dermatologic <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No Fetal (<i>Please complete and attach "ExomeNext Prenatal Form"</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No Genitourinary <input type="checkbox"/> Yes <input type="checkbox"/> No Growth Disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No Undergrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Overgrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Failure to thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No Hematologic <input type="checkbox"/> Yes <input type="checkbox"/> No Immunologic/Infectious/Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Metabolic/Biochemical <input type="checkbox"/> Yes <input type="checkbox"/> No Movement Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Musculoskeletal/Structural <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Congenital Anomalies <input type="checkbox"/> Yes <input type="checkbox"/> No Neurologic <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autism Spectrum Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental Delay/Intellectual disability <input type="checkbox"/> Yes <input type="checkbox"/> No Ataxia/Spasticity <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal brain MRI <input type="checkbox"/> Yes <input type="checkbox"/> No Obstetric <input type="checkbox"/> Yes <input type="checkbox"/> No Oncologic
	<input type="checkbox"/> Yes <input type="checkbox"/> No Ophthalmologic <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary <input type="checkbox"/> Yes <input type="checkbox"/> No Renal <input type="checkbox"/> Yes <input type="checkbox"/> No Tone abnormalities <input type="checkbox"/> Yes <input type="checkbox"/> No Hypotonia <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertonia
ADDITIONAL CLINICAL DETAILS	
Autism: <input type="checkbox"/> no autistic behaviors <input type="checkbox"/> autistic behaviors (describe): _____	
Dysmorphic Features (describe): _____	
Congenital Anomalies (describe): _____	
History of Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> diagnosed epilepsy Seizure type(s): _____	
Progressive disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Studies	
MRI/CT studies (findings): _____	
Chromosome analysis: _____ Microarray analysis: _____	
Other molecular studies: _____	
Growth Indices (current): Head circumference: _____% Weight: _____% Height: _____%	
Differential diagnosis/Genes of interest: _____	
FAMILY HISTORY (Please attach pedigree)	
Is anyone in the family affected with a similar phenotype as the proband? <input type="checkbox"/> NO <input type="checkbox"/> YES, please list exact relationship to proband, symptoms and age of onset of symptoms: _____	
Is there any consanguinity (conception between blood relatives) in the family? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes please describe: _____	

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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.

Check	Test Name	Test Code	Description	
For Reflex or Concurrent Testing:				
Test 1: _____		<input type="checkbox"/> Reflex to	Test 2: _____	
		<input type="checkbox"/> Concurrent with		
			<input type="checkbox"/> Reflex to	
			<input type="checkbox"/> Concurrent with	
See Reflex or Concurrent Testing section of the Supplemental Information page.				
SINGLE 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				
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 amniotic fluid culture or CVS				
<input type="checkbox"/> 1262 MCC Reference for maternal blood sample (No Charge)				
OTHER ORDER				
Please visit ambrygen.com/tests for details.				
Test Code: _____ Test Name: _____				
Notes:				
Fragile X syndrome and Chromosomal Microarray				
<input type="checkbox"/>	Fragile X syndrome	4544	FMR1 repeat expansion analysis and methylation studies	
<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 Ambry. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambry: _____	
<i>*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.</i>				
ORDERING CHECKLIST (Required)				
<input type="checkbox"/> Proband specimen				
<input type="checkbox"/> Clinical Genomics TRF with patient & clinician signatures				
<input type="checkbox"/> Clinical history (attach clinic notes)				
<input type="checkbox"/> Medical Necessity Form (insurance orders only) (see page 5)				
<input type="checkbox"/> Copy of Insurance Card (insurance orders only)				
<i>Orders with missing requirements will be placed on hold until all requirements are received.</i>				
ORDERING CHECKLIST (Highly Recommended)				
<input type="checkbox"/> Family member specimens <i>Please send all first degree and other informative relatives within 4 weeks of the order.</i>				
<input type="checkbox"/> Family history or pedigree				
<input type="checkbox"/> Previous test results				

CONTACT INFORMATION
For ExomeNext preverification requests please send the Medical Necessity Form and Clinical Genomics TRF to preverification@ambrygen.com or fax to 949-900-5501. All other documents can be secure uploaded at ambrygen.com/secure-upload , or faxed to 949-900-5501.
AmbryPort is a secure client portal that allows order submission, test status updates, insurance authorization status and report downloads. All required documents can be completed and directly uploaded through AmbryPort during the ordering process or after order submission. Please visit portal.ambrygen.com/signup to sign up.

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Specimen Requirements

Blood/saliva/buccal swab sample from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva/buccal swab sample 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 4 for Maternal Cell Contamination sample submission test codes.

Reflex or Concurrent Testing

Concurrent testing is when multiple tests are initiated at the same time. When multiple tests are ordered on the same test requisition form, testing will be run concurrently unless otherwise specified.

Reflex testing is when a subsequent test is initiated pending the outcome of the initial test. Reflex testing may result in delayed reporting of results.

For reflex test orders:

- Any diagnostic finding at any step will result in cancellation of any subsequent reflex tests.
- Non-diagnostic findings (including VUS or Uncertain results) will automatically reflex to the subsequent test.
- Secondary findings results do not impact whether a subsequent test is initiated or canceled.

ExomeNext Medical Necessity Form - Page 6 of 6

REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is required if you are ordering Exome testing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

- Yes, date performed: _____
- No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

- Multiple abnormalities affecting unrelated organ systems (please specify): _____
- OR two of the following:**
- Abnormality affecting a single organ system(specify): _____
- Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)
- Family history strongly implicating a genetic etiology (please specify findings and relationships): _____
- Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

- Yes (please describe): _____
- No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

- Chromosomal microarray
- Single gene test(s): _____
- Multigene panel(s): _____
- Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

- Imaging study: _____
- Surgery: _____
- Biopsy: _____
- Other: _____