Ambry Genetics®

Specific Site Analysis Test Requisition Form - Page 1 of 3
(Known Familial Alteration Analysis)

COMPLETE ENTIRE FORM TO AVOID DELAYS

To submit an order via email, please send the completed test requisition form to 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)

2. PATIENT INFORMATION

Legal Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Sex Assigned at Birth ☐F ☐M	Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

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

Address	City	State	Zip

Mobile #	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

Specimen ID	Medical Record #

Collection Assistance: ☐Send saliva kit to patient ☐Send buccal kit to patient

PRENATAL SAMPLES ONLY*

Sample type: ☐ Direct CVS ☐ Cultured CVS ☐ Cultured amnio ☐ POC ☐ 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.*

INDICATION(S) FOR TESTING

ICD-10 code(s): | Testing could aid in systemic therapy and/or surgical decision-making for my affected patient ☐ Yes ☐ No

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 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.

☐ 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:

Ambry Genetics®

Patient Name: _____ DOB: _____

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SPECIFIC SITE ANALYSIS (5555)

Positive control: ☐ Sent ☐ To be sent ☐ Not available ☐ 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.

ALTERATION TO BE TESTED	
Gene 1	Alteration 1
Gene 2	Alteration 2
Gene 3	Alteration 3
Gene 4	Alteration 4

PATIENT CLINICAL INFORMATION

☐ Healthy ☐ 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? ☐ Yes ☐ No Family previously tested at Ambry? ☐ Yes ☐ 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

☐ 1260 MCC for fetal specimen or cord blood ☐ 1262 MCC Reference for maternal blood sample (No Charge)

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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 bottom of 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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