

**COMPLETE TO SUBMIT FAMILY MEMBERS FOR EXOME ORDERS**

All family member specimens must be received within 4 weeks of order to be included in analysis

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

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 <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	<input type="checkbox"/> Current diagnosis of heme malignancy, Type:
Specimen ID	Medical Record #

Collection Assistance:  Phlebotomy draw\*\*  Insurance preverification first  Send saliva kit to patient  Send buccal kit to patient  
 \*\*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
Is family member affected with the same phenotype as the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly, describe: _____

TEST MENU	
<input type="checkbox"/> 9993-9996 Family member for ExomeNext® (no charge) <input type="checkbox"/> 9500 Family member for ExomeNext-Select (no charge) <input type="checkbox"/> 9999R Family member for ExomeNext-Rapid® (no charge) <input type="checkbox"/> Other _____ (Test Code/Test Name)	Proband Name: _____ Relationship to proband: _____

SECONDARY FINDINGS
<p>Secondary findings results are available for each family member sequenced as part of the trio.</p> <p>Check below to opt-out of the ACMG Recommended List of secondary findings. <b>If left unchecked, secondary findings will be reported.</b> Secondary findings are not available for ExomeNext-Select orders.</p> <p><input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.</p>

ORDERING PHYSICIAN/SENDING FACILITY (Each listed person will receive a copy of the report)												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Facility Name (Facility Code)</td> <td style="width: 25%;">Address</td> <td style="width: 15%;">City</td> <td style="width: 15%;">State /Country</td> <td style="width: 10%;">Zip</td> <td style="width: 20%;">Phone</td> </tr> <tr> <td>Ordering Licensed Provider Name (Last, First)(Code)</td> <td>NPI#</td> <td>Phone</td> <td colspan="3">Fax/Email</td> </tr> </table>	Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone	Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email		
Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone							
Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email									

ADDITIONAL RESULTS RECIPIENTS		
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Genetic Counselor or Other Medical Provider Name (Last, First) (Code)</td> <td>Phone/Fax/Email</td> </tr> </table>	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 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:
----------------------------------------------------------------------	-------

**Family Member Acknowledgement:** I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the whole-exome sequencing process prior to testing, and I would like to proceed with test processing. I understand that the primary exome testing is being performed in order to assist analysis for my family member (proband), that a primary report will only be generated for the proband, and that it may be possible to infer information about my results based on the proband's report.

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 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.

If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.

Family Member/Guardian Signature: _____	Date: _____
-----------------------------------------	-------------

For all exome orders, Ambry includes testing for co-segregation analysis (aka: family testing for candidate alterations) if samples are sent before testing begins.

## 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.