

PATIENT INFORMATION				
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	

*Copy of front/back of insurance card and additional payer-specific authorization forms are required.

SPECIMEN TRANSPORT <input type="checkbox"/> Room Temperature	
Collection Date (MM/DD/YY): _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Collection date is required for testing to proceed. Failure to provide may result in delays and/or test cancellation.	Number of Specimens Submitted: _____
Specimen Details: Tissue Type (e.g. skin): _____ Site (e.g. left arm): _____ Sample Type (e.g. punch biopsy): _____	
Testing laboratory handling instructions: Sample will be cultured at Baylor Genetics; 2 (two) T-25 flasks will be sent to Ambray Genetics for testing. Sample will not be frozen for long-term storage.	
FedEx tracking number:	Comments and Special Instructions:

ORDERING PHYSICIAN OR OTHER LICENSED MEDICAL PROFESSIONAL			Facility Type: <input type="checkbox"/> Physician/Physician Group <input type="checkbox"/> Referral Lab	
Name (Last, First, Degree)		Facility Name		NPI#
Kit Shipment Street Address		City	State	Zip
Phone	Fax		E-mail	

ADDITIONAL RESULTS RECIPIENTS	
Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

PATIENT CLINICAL HISTORY			
Describe (attach clinical notes, family notes)			
Personal History <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of Dx	Diagnosis Notes	ICD-10 Code(s)
Family History <input type="checkbox"/> Yes <input type="checkbox"/> No	Family History Details		
Prior Genetic Testing <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient		Family

TEST ORDER	
Order Code: 8814 Tissue Culture Baylor Genetics (AG: 7030) <input type="checkbox"/> Grow and Send	Ambry Billing ID: AGAC
Please include the desired Ambry Genetics' test name and test code.	
Test Name: _____	Test Code: _____
Will patient management be changed depending on the test results? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes:	

Patient Signature (I agree to terms below):	Date:
Medical Professional Signature (I agree to terms below):	Date:

TERMS AND CONDITIONS
<p>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 Ambray Genetics Corporation (Ambray), authorize <u>Ambray</u> 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 responsible for sending Ambray money received from my health insurance company.</p> <p>For NY residents: <input type="checkbox"/> By checking this box, I agree that Ambray 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, Ambray Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.</p> <p>Medical Professional: 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 Ambray 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.</p>

Test Requisition for Tissue Culturing

INSTRUCTIONS FOR SUBMITTING SAMPLE TO BAYLOR GENETICS :

KIT REQUEST

1. 7-10 days prior to patient's procedure, please place an order for a Baylor Genetics' CVS Transport Media Kit through their website at baylorgenetics.com/supplies.
2. On step 3 select "custom options". On step 4 enter TC 8814 at the top and enter the desired qty of 15ml Conical Tube(s) CVS Transport Media.
3. For any questions, please contact Baylor Genetics' Client Services at 1-800-411-4363 or email help@baylorgenetics.com.
4. Upon receipt of the online kit request, Baylor Genetics will ship a CVS Transport Media Kit to the requested address, which should arrive within 3-5 business days. For urgent kit requests, expedited shipping options are available.

PREPARING SAMPLE

Upon receiving the kit, place tube with media in the refrigerator until ready for use.

Specimen preparation: Collect 5 cubic millimeters of skin from a central location (e.g. buttock or upper thigh) rather than from a distal location (e.g. foot) to enhance cell viability. Place sample in a separate sterile container with RPMI media (included in the Baylor Genetics' CVS Transport Media Kit). In the absence of RPMI media, place sample along with a small amount of sterile saline in a sterile container with a cap that can be tightened to prevent leakage. Never place samples in formalin or other fixative.

Storage/transport temperature: Ship at room temperature in an insulated container by overnight courier. Do NOT heat or freeze.

Stability: Sample must arrive at culture lab within 48 hrs. of collection.

For questions related to tissue culturing, please contact Baylor Genetics' Client Services at 1-800-411-4363 or email help@baylorgenetics.com.

SHIPPING

1. Include completed Test Requisition Form with the CVS Transport Media Kit and provide FedEx tracking number.
2. Fax (949-900-5501) or email (CulturedSamples@ambrygen.com) completed Test Requisition Form to Ambry Genetics.
3. Ship sample to Baylor Genetics at 2450 Holcombe Blvd, Grand Blvd. Receiving Dock, Houston, TX 77021-2024.

Please note that fibroblast cultures typically take 2-3 weeks to complete.

If multiple skin biopsy specimens are collected, only one biopsy specimen will be cultured and sent to Ambry. If you require an exception to the standard specimen processing, please notify Baylor upon sample submission (additional charges may apply). Remaining cultures at Baylor Genetics will be discarded 14 days after sending initial 2 T2Ss to Ambry, unless additional cultures are requested prior to discard.

For questions related to acceptable specimens, test status, or results, please contact Ambry Genetics at 949-900-5500.