

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

**1. SPECIMEN INFORMATION** (Please see [ambrygen.com/specimen-requirements](http://ambrygen.com/specimen-requirements) for details)

**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)

**PLEASE SUBMIT THE FOLLOWING WITH THE TRF:**

1. Clinic Notes    2. Pedigree    3. Insurance Card and Authorization Documents

**2. PATIENT INFORMATION**

Legal Name (Last, First, MI)		Date of Birth (MM/DD/YY)	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:				MRN
Address		City		State      Zip
Mobile #	Email		Preferred Billing <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	

**3. ORDERING PROVIDER INFORMATION**

Organization Name, Number	Address	City, State	Zip
Ordering Provider Name (Last, First), Ambry Number, NPI <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Counselor/Other Healthcare Professional Name (Last, First), Ambry Number <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. PERSONAL AND FAMILY HISTORY OF CANCER** Attach clinic notes and/or pedigree

Personal History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of Dx: _____	Metastatic: <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor is <input type="checkbox"/> MSI-High or <input type="checkbox"/> IHC-Abnormal	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			Abnormal IHC Result: _____	
Patient Cancer Type Details: _____				<input type="checkbox"/> TNBC
Family History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Known Familial Variant: <input type="checkbox"/> Family <input type="checkbox"/> Self    Gene: _____   Variant (c. and/or p.): _____    Ambry ID: _____			
<input type="checkbox"/> My patient is the most informative family member available for testing. The affected relative and all intervening relatives are either deceased or unwilling/unavailable for testing.				

Relationship to Patient	Mat	Pat	Age at Dx	Family Testing and Cancer Type Details	Reason relative has not been tested
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact

**5. TEST ORDERS**

<b>REQUIRED: Select a Primary Test Order</b>	<b>Select an Optional Supplemental Test</b> (Per payer policy, all tests in this section will be processed and billed separately; tests may be performed as a reflex.)	
For Patients Meeting <i>BRCA1/2</i> Testing Criteria <input type="checkbox"/> <i>BRCA1/2</i> test	<input type="checkbox"/> CancerNext® (8824) <input type="checkbox"/> BRCAplus® (8836) <input type="checkbox"/> BRCANext® (8857) Add on: <input type="checkbox"/> Limited Evidence	<input type="checkbox"/> CancerNext-Expanded® (8875) Add on: <input type="checkbox"/> Limited Evidence <input type="checkbox"/> Pancreatitis <input type="checkbox"/> CustomNext-Cancer® (9511) Notes: _____ <input type="checkbox"/> Specific Site Analysis (5555): Proband report is required. Gene: _____ Variant (c./p.): _____ <input type="checkbox"/> Other: _____
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch) Lynch Syndrome test: <input type="checkbox"/> <i>MLH1, MSH2, MSH6, PMS2, EPCAM</i>	<input type="checkbox"/> ColoNext® (8821) Add on: <input type="checkbox"/> Limited Evidence	
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis) Polyposis test: <input type="checkbox"/> <i>APC/MUTYH</i>		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above (patient does not meet any genetic testing criteria)	<b>Other Supplemental Test Options (Select if applicable)</b> <input type="checkbox"/> +RNAinsight® (Not available with BRCAplus or STAT orders; PAXgene® tube required for RNA)	

Collection Assistance:  Phlebotomy draw    Send saliva kit to patient    Send buccal swab kit to patient

STAT TEST:  Date results needed (if known): \_\_\_\_\_   **Was genetic counseling completed?**  Yes    No    Unknown    Date Genetic Counseling was Performed: \_\_\_\_\_

Patient Signature (I agree to terms on the next page):	Date:
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Medical Professional Signature (I agree to terms on the next page):	Date:
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**TERMS AND CONDITIONS**

**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.

**For NY Residents:**  I understand that New York State law requires Ambry Genetics to destroy my sample at the end of the testing process or not more than sixty days after the sample was taken. By checking this box, I agree that Ambry Genetics will instead retain my sample for at least 6 months after the testing above has been completed, and may (a) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (b) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

**Medical Professional:** Confirmation of Informed Consent, Pre-test Genetic Counseling, and Medical Necessity for Genetic Testing  
 I confirm that the genetic test ordered is medically appropriate. All information on this TRF is true to the best of my knowledge. I also confirm that the patient has consented to proceed with genetic testing, including the transfer and processing of their sample and personal/sensitive information in the United States. 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.

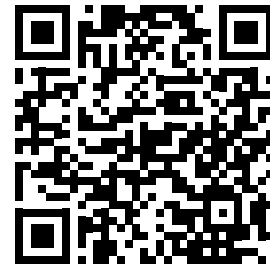
## Supplemental Information

Electronic ordering is also available via AmbryPort®. Please visit <https://portal.ambrygen.com/login> to log in to the online portal.

### Hereditary Cancer Multi-Gene Tests

For current hereditary cancer panel gene content, please visit [www.ambrygen.com/providers/oncology/test-menu](http://www.ambrygen.com/providers/oncology/test-menu) (linked to QR code below).

TEST NAME	TEST CODE
Pan-cancer	
CancerNext®	8824
CancerNext-Expanded®	8875
STAT Breast Management	
BRCAPlus®	8836
Breast & gynecologic	
BRCANext®	8857
Colorectal & polyposis	
ColoNext®	8821
Customizable	
CustomNext-Cancer® Required: complete CustomNext-Cancer supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>	9511
Syndrome specific	
Adenomatous polyposis	8726
BRCA1/2-associated hereditary breast and ovarian cancer (HBOC)	8838
Lynch syndrome	8517



Scan for current hereditary cancer panel gene content

## 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. Please 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.

Specific site analysis for variants identified at an external laboratory must be accompanied by a copy of the original testing report. A positive control from a known positive family member is recommended (required for prenatal testing).

### 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.

When ordering STAT panels (such as BRCAplus®), the results of the STAT panel will be prioritized and reported with a shorter turnaround time, even if the tests were run concurrently.

### Known Familial Variants

Variant-specific report comments about the presence or absence of known familial variant(s) require the "Known Familial Variant" section of this form to be completed accurately, including an internal Ambry reference ID and/or a copy of the positive family member's lab report. Acceptable types of Ambry identifiers include:

- Accession number
- Order number
- Name and date of birth

Variant requests without an internal Ambry reference ID or positive family member's lab report will not receive a variant-specific report comment.