

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

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 Ambry 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		
Name (Last, First, Degree)		Facility Name
Kit Shipment Street Address		NPI#
Phone	City	State Zip
	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 (cancer type, etc.)	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	
Known Familial Variant <input type="checkbox"/> Family <input type="checkbox"/> Self See instructions on the following page	Gene	Variant (c. and/or p.)	Testing Lab Ambry ID

TEST ORDERS	
Will the course of treatment change depending upon the results of the test? <input type="checkbox"/> Yes <input type="checkbox"/> No	STAT TEST: <input type="checkbox"/> Date results needed (if known): _____
<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.	
Was genetic counseling completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date Genetic Counseling was Performed: _____	
Order Code: 8814 Tissue Culture Baylor Genetics (AG: 7030) <input type="checkbox"/> Grow and Send Ambry Billing ID: AGAC	

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

Non-Oncology Test Orders	
For non-oncology test orders, please include the desired Ambry Genetics test name and test code below. Test Name: _____ Test Code: _____	

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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Test Requisition for Tissue Culturing (Comprehensive)

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 responsible for sending Ambry money received from my health insurance company.

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.

INSTRUCTIONS FOR SUBMITTING SAMPLE TO BAYLOR GENETICS :

KIT REQUEST

- 7-10 days prior to patient's procedure, please place an order for a Baylor Genetics' Tissue (Biopsy, Products of Conception)* Kit through their website at baylorgenetics.com/supplies.
- In the "Tissue (Biopsy, Products of Conception)" field, enter the desired quantity of 15ml conical tube(s) of transport media. Also complete the "When do you need the kit(s) by" field.
- For any questions, please contact Baylor Genetics' Client Services at 1-800-411-4363 or email help@baylorgenetics.com.
- Upon receipt of the online kit request, Baylor Genetics will ship a Tissue Kit to the requested address, which should arrive within 3-5 business days. For urgent kit requests, expedited shipping options are available.

* Prenatal specimens should not be submitted through this workflow.

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' Tissue 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.

POSITIVE CONTROL

Known variant analysis should be accompanied by a copy of the original testing report or internal Ambry testing information (internal Ambry ID, Name/DOB). Please review information about positive controls and other specifics at ambrygen.com/knownvariantanalysis.

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.

SHIPPING

- Include completed Test Requisition Form with the Tissue Kit and provide FedEx tracking number.
- Fax (949-900-5501) or email (CulturedSamples@ambrygen.com) completed Test Requisition Form to Ambry Genetics.
- 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.

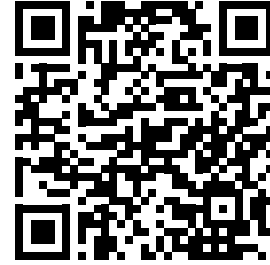
For questions related to acceptable specimens, test status, or results, please contact Ambry Genetics at 949-900-5500.

Supplemental Information

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

For current hereditary cancer panel gene content, please visit 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. ambrygen.com/forms	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

For cardiology testing options, please visit www.ambrygen.com/providers/cardiology/test-menu (linked to QR code below)



For neurology testing options, please visit www.ambrygen.com/providers/neurology/test-menu (linked to QR code below)



For exome & general genetics testing options, please visit www.ambrygen.com/providers/exome-and-general-genetics/test-menu (linked to QR code below)

