

**COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS**

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 style="font-size: 0.8em; margin: 0;">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)	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 INFORMATION* (Please see <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details)	
<input type="checkbox"/> Personal history of allogeneic bone marrow or peripheral stem cell transplant	<input type="checkbox"/> Current diagnosis of heme malignancy, Type:
Specimen ID:	Medical Record #

\*Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see page 4 for Maternal Cell Contamination sample submission test codes

Collection Assistance:  Phlebotomy draw\*\*  Send saliva kit to patient  Send buccal kit to patient |  Insurance preverification first (available for ExomeNext® only)

\*\* 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.

ORDERING PHYSICIAN/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	Fax/Email	

ADDITIONAL RESULTS RECIPIENTS	
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

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.

<b>Signature Required for Processing</b> Medical Professional Signature:	Date:
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<input type="checkbox"/> INSURANCE BILLING (Include copy of both sides of insurance card)			<input type="checkbox"/> INSTITUTIONAL BILLING	
Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name and DOB of Policy Holder (if not self)	HMO Auth #	Facility Name	<input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #		Address	
Special Billing Notes:			Contact Name	
			Phone Number	E-mail/Fax
			<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> 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.

**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.

<b>Patient Signature (I agree to terms above):</b>	Date:
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# Clinical Genomics Test Requisition Form - Page 2 of 6

**ONLY COMPLETE FOR EXOMENEXT-DUO/TRIO ORDERS OR IF FAMILY MEMBERS WILL BE SUBMITTED FOR CO-SEGREGATION.**  
 All family member specimens must be received within 4 weeks of order. Otherwise test will be run as proband only.

FAMILY MEMBER #1 INFORMATION				
Legal Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
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:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State	Zip
				Relationship to proband

SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements 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:
Collection Date	Specimen ID	Medical Record #
<small>*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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.</small>		
<small>Collection Assistance: <input type="checkbox"/> Phlebotomy draw** <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient   <input type="checkbox"/> Insurance preverification first (available for ExomeNext® only)                  ** 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.</small>		

CLINICAL INFORMATION
Does the family member have any features similar to the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly
Describe:

SECONDARY FINDINGS
Secondary findings results are available for each family member sequenced as part of the trio. Check "decline" to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported for this family member.
<input type="checkbox"/> Decline

FAMILY MEMBER #2 INFORMATION				
Legal Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
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:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State	Zip
				Relationship to proband

SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements 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:
Collection Date	Specimen ID	Medical Record #
<small>*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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.</small>		
<small>Collection Assistance: <input type="checkbox"/> Phlebotomy draw** <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient   <input type="checkbox"/> Insurance preverification first (available for ExomeNext® only)                  ** 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.</small>		

CLINICAL INFORMATION
Does the family member have any features similar to the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly
Describe:

SECONDARY FINDINGS
Secondary findings results are available for each family member sequenced as part of the trio. Check "decline" to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported for this family member.
<input type="checkbox"/> Decline

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INDICATION(S) FOR TESTING		
ICD-10 code(s):	Will medical management change depending upon the results of the test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PROBAND'S PRIMARY INDICATION FOR TESTING		
Please describe in a few words the main reason for ordering exome testing ( <i>Please also provide clinic notes and pedigree</i> ):		
PROBAND'S CLINICAL OVERVIEW (Check yes for all that apply)		
<input type="checkbox"/> Yes <input type="checkbox"/> No Audiologic/Otolaryngologic <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No Craniofacial <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Dysmorphic Features <input type="checkbox"/> Yes <input type="checkbox"/> No Dermatologic <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No Fetal ( <i>Please complete and attach "ExomeNext Prenatal Form"</i> ) <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No Genitourinary <input type="checkbox"/> Yes <input type="checkbox"/> No Growth Disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No Undergrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Overgrowth <input type="checkbox"/> Yes <input type="checkbox"/> No Failure to thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No Hematologic <input type="checkbox"/> Yes <input type="checkbox"/> No Immunologic/Infectious/Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Metabolic/Biochemical <input type="checkbox"/> Yes <input type="checkbox"/> No Movement Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Musculoskeletal/Structural <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Congenital Anomalies <input type="checkbox"/> Yes <input type="checkbox"/> No Neurologic <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autism Spectrum Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental Delay/Intellectual disability <input type="checkbox"/> Yes <input type="checkbox"/> No Ataxia/Spasticity <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal brain MRI <input type="checkbox"/> Yes <input type="checkbox"/> No Obstetric <input type="checkbox"/> Yes <input type="checkbox"/> No Oncologic	<input type="checkbox"/> Yes <input type="checkbox"/> No Ophthalmologic <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary <input type="checkbox"/> Yes <input type="checkbox"/> No Renal <input type="checkbox"/> Yes <input type="checkbox"/> No Tone abnormalities <input type="checkbox"/> Yes <input type="checkbox"/> No Hypotonia <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertonia
ADDITIONAL CLINICAL DETAILS		
Autism: <input type="checkbox"/> no autistic behaviors <input type="checkbox"/> autistic behaviors (describe): _____		
Dysmorphic Features (describe): _____		
Congenital Anomalies (describe): _____		
History of Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> diagnosed epilepsy Seizure type(s): _____		
Progressive disease <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Previous Studies</b>		
MRI/CT studies (findings): _____		
Chromosome analysis: _____ Microarray analysis: _____		
Other molecular studies: _____		
Growth Indices (current): Head circumference: _____% Weight: _____% Height: _____%		
Differential diagnosis/Genes of interest: _____		
Previously Reported Variants*:		
Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____		
Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____		
Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____		
<small>*See instructions for reporting of Previously Reported Variants on the Supplemental Information Page</small>		
FAMILY HISTORY (Please attach pedigree)		
Is anyone in the family affected with a similar phenotype as the proband? <input type="checkbox"/> NO <input type="checkbox"/> YES, please list exact relationship to proband, symptoms and age of onset of symptoms: _____ _____		
Is there any consanguinity (conception between blood relatives) in the family? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes please describe: _____		
Known Familial Variant: Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____		

## Clinical Genomics Test Requisition Form - Page 4 of 6

Please check the box next to the test(s) being ordered below. If this TRF is sent to Ambry without or ahead of the sample, it will be treated as a preverification. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample. Preverification will only be performed for ExomeNext® testing.

Check	Test Name	Test Code	Description	
<b>For Reflex or Concurrent Testing:</b>				
Test 1: _____		<input type="checkbox"/> Reflex to	Test 2: _____	
		<input type="checkbox"/> Concurrent with		
		<input type="checkbox"/> Reflex to	Test 3: _____	
		<input type="checkbox"/> Concurrent with		
See Reflex or Concurrent Testing section of the Supplemental Information page.				
				<b>KNOWN VARIANT ANALYSIS (Please include a copy of relative's report)</b>
				Gene(s): _____ Variant(s) (c. and/or p.): _____
				Relative Name: _____
				Relationship to Relative: _____ Accession # (If tested at Ambry): _____
				Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available
				<b>FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED</b>
				Both test codes required for fetal specimens.
				<input type="checkbox"/> 1260 MCC for amniotic fluid culture or CVS
				<input type="checkbox"/> 1262 MCC Reference for maternal blood sample (No Charge)
				<b>OTHER ORDER</b>
				Please visit <a href="http://ambrygen.com/tests">ambrygen.com/tests</a> for details.
				Test Code: _____ Test Name: _____
				Notes:
				<b>ORDERING CHECKLIST (Required)</b>
				<input type="checkbox"/> Proband specimen
				<input type="checkbox"/> Clinical Genomics TRF with patient & clinician signatures
				<input type="checkbox"/> Clinical history (attach clinic notes)
				<input type="checkbox"/> Medical Necessity Form (insurance orders only) (see page 5)
				<input type="checkbox"/> Copy of Insurance Card (insurance orders only)
				<i>Orders with missing requirements will be placed on hold until all requirements are received.</i>
				<b>ORDERING CHECKLIST (Highly Recommended)</b>
				<input type="checkbox"/> Family member specimens <i>Please send all first degree and other informative relatives within 4 weeks of the order.</i>
				<input type="checkbox"/> Family history or pedigree
				<input type="checkbox"/> Previous test results
<b>CONTACT INFORMATION</b>				
For ExomeNext preverification requests please send the Medical Necessity Form and Clinical Genomics TRF to <a href="mailto:preverification@ambrygen.com">preverification@ambrygen.com</a> or fax to 949-900-5501.				
All other documents can be secure uploaded at <a href="http://ambrygen.com/secure-upload">ambrygen.com/secure-upload</a> , or faxed to 949-900-5501.				
AmbryPort is a secure client portal that allows order submission, test status updates, insurance authorization status and report downloads. All required documents can be completed and directly uploaded through AmbryPort during the ordering process or after order submission. Please visit <a href="http://portal.ambrygen.com/signup">portal.ambrygen.com/signup</a> to sign up.				

### CONTACT INFORMATION

For ExomeNext preverification requests please send the Medical Necessity Form and Clinical Genomics TRF to [preverification@ambrygen.com](mailto:preverification@ambrygen.com) or fax to 949-900-5501.

All other documents can be secure uploaded at [ambrygen.com/secure-upload](http://ambrygen.com/secure-upload), or faxed to 949-900-5501.

AmbryPort is a secure client portal that allows order submission, test status updates, insurance authorization status and report downloads. All required documents can be completed and directly uploaded through AmbryPort during the ordering process or after order submission. Please visit [portal.ambrygen.com/signup](http://portal.ambrygen.com/signup) to sign up.

## Supplemental Information - Page 5 of 6

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

### Specimen Requirements

Blood/saliva/buccal swab sample from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva/buccal swab sample 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.

Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see page 4 for Maternal Cell Contamination sample submission test codes.

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](https://ambrygen.com/knownvariantanalysis).

### Previously Reported Variants

ExomeNext® report comments about the presence or absence of a variant previously reported **in the patient** require the "Previously Reported 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

Previously reported variant requests without an internal Ambry reference ID or positive lab report will not receive a variant-specific report comment.

Variant-specific report comments about the presence or absence of a variant previously reported **in a family member** are not included in ExomeNext or Neurology panel reports.

### 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.

## ExomeNext Medical Necessity Form - Page 6 of 6

### REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is required if you are ordering Exome testing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

- Yes, date performed: \_\_\_\_\_  
 No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

- Multiple abnormalities affecting unrelated organ systems (please specify): \_\_\_\_\_  
**OR two of the following:**  
 Abnormality affecting a single organ system(specify): \_\_\_\_\_  
 Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)  
 Family history strongly implicating a genetic etiology (please specify findings and relationships): \_\_\_\_\_  
 Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

- Yes (please describe): \_\_\_\_\_  
 No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

- Chromosomal microarray  
 Single gene test(s): \_\_\_\_\_  
 Multigene panel(s): \_\_\_\_\_  
 Other genetic test(s): \_\_\_\_\_

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

- Imaging study: \_\_\_\_\_  
 Surgery: \_\_\_\_\_  
 Biopsy: \_\_\_\_\_  
 Other: \_\_\_\_\_