Ambry Genetics®
A TEMPUS COMPANY

Comprehensive Test Requisition Form - Page 1 of 6

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

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)

PATIENT INFORMATION

Legal Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Sex Assigned at Birth ☐F ☐M	Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

Genetic Ancestry: ☐Ashkenazi Jewish ☐Asian ☐Black/African American ☐French Canadian/Cajun ☐Hispanic/Latino ☐Mediterranean ☐Middle Eastern ☐Native American ☐Pacific Islander ☐Portuguese ☐White ☐Unknown ☐Other:

MRN

Address	City	State	Zip

Mobile #	Email

SPECIMEN INFORMATION* (Please see ambrygen.com/specimen-requirements for details)

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

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 bottom of page 5 for Maternal Cell Contamination sample submission test codes.*

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

INDICATION(S) FOR TESTING

ICD-10 code(s):

Will the medical management change depending on the results of the test? ☐ Yes ☐ No

Was genetic counseling completed? ☐ Yes ☐ No ☐ Unknown Date Genetic Counseling was Performed: _____

PRENATAL SAMPLES ONLY

Sample type: ☐ Direct CVS ☐ Cultured CVS ☐ Cultured amnio ☐ POC ☐ Cultured POC | Gestational age at sample collection

ORDERING LICENSED PROVIDER/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/Email

ADDITIONAL RESULTS RECIPIENTS

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, 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.

Signature Required for Processing Medical Professional Signature: Date:

☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Auth #

Special Billing Notes:

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*

Address

Contact Name

Phone Number	Email/Fax

☐ PATIENT PAYMENT

☐ Check (Payable to Ambry Genetics)
☐ 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.

Patient Signature (I agree to terms above): Date:

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Patient Name: _____ DOB: _____

Comprehensive Test Requisition Form - Page 2 of 6

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

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

CLINICAL HISTORY

PLEASE ATTACH PEDIGREE /CLINICAL CONSULTATION NOTES, IF AVAILABLE

Birth and Neonatal History ☐ Not Applicable

Gestational age at birth: _____ Birth weight: _____

Head circumference at birth (if available): _____

☐ Congenital anomalies, explain: _____

☐ Positive newborn screen, explain: _____

Seizure History ☐ Not Applicable

Age at first unprovoked seizure (first seizure without fever or other acute metabolic or structural cause): _____

Seizure types (choose all that apply):

☐ Infantile/epileptic spasms ☐ Myoclonic ☐ Generalized tonic clonic
☐ Tonic ☐ Typical absence ☐ Focal seizures
☐ Atonic ☐ Atypical absence

Are seizures: ☐ refractory ☐ well-controlled

Has this patient been diagnosed with an epilepsy syndrome?

☐ yes ☐ no ☐ unknown If yes, please specify: _____

Pulmonology History ☐ Not Applicable

☐ Positive newborn screen ☐ CBAVD ☐ Meconium ileus

☐ Infections: _____

☐ Sweat chloride: _____mmol/L ☐ Sweat chloride: ☐<40 ☐ 40-60 ☐ >60

☐ Pancreatic insufficiency IRT level: _____

☐ Respiratory distress, explain: _____

☐ Respiratory assistance devices: _____

☐ Ultrasound findings: _____

Developmental History ☐ Not Applicable

Developmental delay: ☐ yes ☐ no ☐ unknown

Delay prior to seizure onset: ☐ yes ☐ no ☐ unknown ☐ N/A

Type of delay (choose all that apply): ☐ motor ☐ language ☐ global

Intellectual disability: ☐ yes ☐ no ☐ unknown

Regression or plateau: ☐ yes ☐ no ☐ unknown

Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder?:

☐ yes ☐ no ☐ unknown

Cardiac History ☐ Not Applicable

Sudden cardiac arrest ☐ Y ☐ N (if yes): # Episodes: _____

Age first incident: _____

Syncope ☐ Y ☐ N If yes, # Episodes: _____ Age first incident: _____

History of cardiomyopathy ☐ Y ☐ N Age at dx: _____

Cardiomyopathy type: _____

History of Arrhythmia ☐ Y ☐ N Age at dx: _____

Arrhythmia type: _____

☐ Congenital heart defect _____

Other History ☐ Not Applicable

☐ Hearing problems: _____ ☐ Vision problems: _____

☐ Migraine: _____ ☐ Psychiatric: _____

☐ Hematological: _____

☐ Suspected genetic condition: _____

☐ Other clinical findings: _____

Cancer History ☐ Not Applicable Metastatic: ☐ Yes ☐ No Tumor is ☐ MSI-High or ☐ IHC-Abnormal

Cancer/Tumor	Age at Dx	Pathology and Other Info
Brain		
Breast		Type: ER ☐(+) ☐(-) ☐unk PR ☐(+) ☐(-) ☐unk HER2/neu ☐(+) ☐(-) ☐unk
2nd primary breast		Type: ER ☐(+) ☐(-) ☐unk PR ☐(+) ☐(-) ☐unk HER2/neu ☐(+) ☐(-) ☐unk
Colorectal		Location:
Ovarian		☐ Fallopian tube ☐ Primary peritoneal
Melanoma/skin		
Prostate		Gleason Score:
Uterine		
Hematologic*		Type: ☐ Allogenic bone marrow or peripheral stem cell transplant*
Other Cancer		Type:
GI polyps		☐ Adenomatous Polyp #: ☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+ ☐ Other type: Polyp #: ☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+

**Blood or saliva from patients with active/recent hematological disease will undergo additional review and may not be accepted in some cases. For these, cultured fibroblasts or fresh/fresh frozen normal tissue are preferred. See ambrygen.com/specimen-requirements for details.*

PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory) ☐ Limited family history

Known Familial Variant: ☐ Family ☐ Self Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____

See instructions on the Supplemental Information Page

Patient previously tested at Ambry? ☐ Yes ☐ No Family previously tested at Ambry? ☐ Yes ☐ No

Name: _____ DOB: _____ Relation: _____

☐ 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.

FAMILY MEMBER INFORMATION (Completion of this section is required for orders including parental samples)

Mother - Name: _____ DOB: _____ ☐ unaffected ☐ affected, list symptoms/dx: _____ Dx age: _____

Father - Name: _____ DOB: _____ ☐ unaffected ☐ affected, list symptoms/dx: _____ Dx age: _____

Relationship to Patient	Mat	Pat	Age at Dx	Family Testing and Cancer Type Details	Reason relative has not been tested
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact

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Patient Name: _____ DOB: _____

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.

CANCER TEST ORDERS

Primary Test Order

! **REQUIRED: Select a Primary Test Order**

For Patients Meeting *BRCA1/2* Testing Criteria	For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)
☐ *BRCA1/2* test	Polyposis test: ☐ *APC/MUTYH*
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)	☐ Other: _____
Lynch Syndrome test: ☐ *MLH1, MSH2, MSH6, PMS2, EPCAM*	☐ None of the above (patient does not meet any genetic testing criteria)

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.)

Order	Test Code	Test Name	Description
☐	8857	BRCANext®	Breast & gynecologic cancer test
		Add on: ☐ Limited Evidence	
☐	8836	BRCAPlus®	STAT breast management test
☐	8824	CancerNext®	Pan-cancer test
☐	8875	CancerNext-*Expanded*®	Pan-cancer test
		Add on: ☐ Limited Evidence	
		Add on: ☐ Pancreatitis	

Order	Test Code	Test Name	Description
☐	8821	ColoNext®	Colorectal cancer & polyposis test
		Add on: ☐ Limited Evidence	
☐	9511	CustomNext-*Cancer*® Notes: _____ _____ _____	Custom test Gene content is required. Use CustomNext-*Cancer* supplemental form for guidance.

Other Supplemental Test Options (Select if applicable)

☐ +RNAinsight® (Not available with BRCAplus, or STAT orders; PAXgene® tube required for RNA)

Order	Test Name	Test Code	Description
Breast and/or Ovarian Cancer			
☐	*ATM*	9014	Ataxia-telangiectasia
☐	*BRCA1/2*	8838	Hereditary breast and ovarian cancer
☐	*CHEK2*	9016	
☐	*DICER1*	5260	
☐	*PALB2*	2366	
☐	*PTEN*	2106	*PTEN*-related disorders (including Cowden syndrome)
☐	*TP53*	2866	Li-Fraumeni syndrome
Endocrine Tumors			
☐	*MEN1*	2646	Multiple endocrine neoplasia type 1
☐	*RET* gene sequence	2680	Multiple endocrine neoplasia type 2
Gastrointestinal Cancer			
☐	*APC*	3040	Familial adenomatous polyposis
☐	*APC* and *MUTYH* concurrent	8726	Adenomatous polyposis
☐	*BMPR1A* and *SMAD4* concurrent	8604	Juvenile polyposis syndrome
☐	*CDH1*	4726	Hereditary diffuse gastric cancer
☐	*EPCAM* del/dup	8519	Lynch syndrome
☐	Lynch syndrome (concurrent)	8517	*MLH1, MSH2, MSH6, PMS2 + EPCAM* del/dup

Order	Test Name	Test Code	Description
Gastrointestinal Cancer (Cont.)			
☐	*MLH1*	8508	Lynch syndrome
☐	*MSH2 + EPCAM* del/dup	8510	Includes *MSH2* inversion
☐	*MSH2* inversion	2226	Lynch syndrome
☐	*MSH6*	8512	Lynch syndrome
☐	*MUTYH*	4661	*MUTYH*-associated polyposis
☐	*PMS2*	4646	Lynch syndrome
☐	*STK11*	2766	Peutz-Jeghers syndrome
Genitourinary Cancer			
☐	*BAP1*	9044	
☐	*FH*	6301	Hereditary leiomyomatosis and renal cell cancer
☐	*FLCN*	5921	Birt-Hogg-Dubé syndrome
☐	*VHL*	2606	Von-Hippel Lindau disease
☐	*TSC1* and *TSC2*	5904	Tuberous sclerosis complex
Skin Cancer/Melanoma			
☐	*CDKN2A* and *CDK4* concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
☐	*PTCH1*	5684	Gorlin syndrome
Other Hereditary Cancer Testing			
☐	*NF1*	5704	Neurofibromatosis type 1
☐	*NF2*	9024	Neurofibromatosis type 2
☐	*RB1*	5426	Hereditary retinoblastoma
☐	*SMARCB1*	7180	Schwannomatosis
Other Single Syndrome Orders			
☐	Please visit ambrygen.com/hereditary-cancer-single-gene-tests for details. Test Code(s): _____ Gene/Test Name(s): _____		

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Patient Name: _____ DOB: _____

CARDIOLOGY

Comprehensive Cardiovascular Panels

Order	Test Name	Test Code	Description
☐	CardioNext®	8911	92 genes for hereditary cardiomyopathies and arrhythmias
☐	CustomNext-*Cardio*®	9520	Up to 167 genes related to hereditary cardiomyopathies, arrhythmias, TAAD, HHT, Noonan, and lipidemias. Required: completed CustomNext-*Cardio* supplemental form. ambrygen.com/forms

Arrhythmia Panels

Order	Test Name	Test Code	Description
☐	LongQTNext™	8890	17 genes for long QT, Brugada and short QT syndromes
☐	RhythmNext®	8900	42 genes for long QT syndrome, Brugada and short QT syndromes, CPVT and ARVC
☐	CPVTNext®	8902	4 genes for catecholaminergic polymorphic ventricular tachycardia

Cardiomyopathy Panels

Order	Test Name	Test Code	Description
☐	HCMNext®	8936	30 genes for hypertrophic cardiomyopathy
☐	HCMNext Reflex	8883	*MYBPC3, MYH7* reflex to HCMNext
☐	DCMNext®	8884	37 genes for dilated cardiomyopathy
☐	CMNext®	8887	56 genes for hereditary cardiomyopathy
☐	ARVCNext™	8904	11 genes for arrhythmogenic right ventricular cardiomyopathy

Familial Hypercholesterolemia

Order	Test Name	Test Code	Description
☐	FHNext®	8680	4 genes (*APOB, LDLR, LDLRAP1, PCSK9*)
☐ Check this box if you would like to have the *SLC01B1* c.521T>C polymorphism reported with FHNext, which has been associated in medical literature with statin-induced myopathies			
☐	FCSNext (Familial Chylomicronemia Syndrome)	8920	*APOA5, APOC2, GPIHBP1, LMF1, LPL*
☐	Sitosterolemia	8930	*ABCG5, ABCG8*

Aneurysms and Related Disorders

Order	Test Name	Test Code	Description
☐	TAADNext®	8789	35 genes for thoracic aortic aneurysms/dissections, Marfan syndrome, Ehlers-Danlos and related disorders
☐	Marfan reflex to TAADNext	8783	*FBN1* reflex to TAADNext

Hereditary Hemorrhagic Telangiectasia (HHT)

Order	Test Name	Test Code	Description
☐	HHTNext®	8672	*ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4*

Noonan Syndrome

Order	Test Name	Test Code	Description
☐	NoonanNext™	8402	18 genes for RASopathies

Other

Order	Test Name	Test Code	Description
☐	Transthyretin amyloidosis	1560	*TTR*

CLINICAL GENOMICS

For Reflex or Concurrent Testing:

Test 1: _____ ☐ Reflex to ☐ Concurrent with Test 2: _____ ☐ Reflex to ☐ Concurrent with Test 3: _____

See Reflex or Concurrent Testing section of the Supplemental Information page.

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: _____

**See instructions for reporting of Previously Reported Variants on the Supplemental Information Page*

Chromosomal Microarray

Order	Test Name	Test Code	Description
☐	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)

Exome

! REQUIRED: Select a Primary Test Order

Order	Test Name	Test Code	Description
☐	ExomeNext® ☐ Proband only ☐ Duo ☐ Trio	9900	Exome sequencing
☐	ExomeNext-*Rapid*®	9999-R	Rapid trio exome sequencing including a defined list of established disease-causing variants in the mitochondrial DNA (mtDNA)

ExomeNext Supplemental Test Options (Primary test order required. See descriptions for details.)

Order	Test Name	Test Code	Description
☐	ACMG Secondary Findings* ☐ Decline	9920	Analysis of genes included in the ACMG Recommended List of secondary findings. Secondary findings results are available free of charge for the proband and each family member who is fully sequenced as part of the duo/trio.
☐	ExomeReveal® RNA Analysis	9990	RNA analysis is available with all ExomeNext orders except for ExomeNext-*Rapid*. EDTA and PAX-gene RNA tubes are required.
☐	Mito DNA	9900-M	Analysis of a defined list of established disease-causing variants in the mitochondrial DNA (mtDNA)

** Secondary Findings: Check "decline" to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported.*

ENDOCRINOLOGY

Order	Test Name	Test Code	Description
☐	Hereditary leiomyomatosis renal cell carcinoma	6301	*FH*
☐	Multiple endocrine neoplasia type I	2646	*MEN1*
☐	Multiple endocrine neoplasia type 2 and familial medullary thyroid cancer (FMTC)	2680	*RET* gene sequence
☐	Neurofibromatosis type 1	5704	*NF1*
☐	von-Hippel Lindau disease	2606	*VHL*

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Patient Name: _____ DOB: _____

GASTROENTEROLOGY

☐	*CFTR* gene sequence and deletion/duplication analysis	1007	☐ Report poly T/TG status
☐	Hirschsprung disease (*RET*-related)	2680	*RET* gene sequence

☐	Juvenile polyposis syndrome	8604	*BMPR1A, SMAD4*
☐	Pancreatitis	8022	*CFTR, CPA1, CTRC, PRSS1, SPINK1*
☐	Peutz-Jeghers syndrome	2766	*STK11*

HEMATOLOGY/ONCOLOGY

☐	Shwachman-Diamond syndrome	1440	*SBDS*

NEUROLOGY

☐ **Opt-in to Reporting of Variants of Unknown Significance (VUS)**
For patients undergoing an epilepsy or neurodevelopmental disorder panel, checking this box indicates that VUS identified on the test(s) ordered below will be reported for this patient. If you do not check this box, VUS will NOT be reported.

☐ **Parental samples provided for cosegregation**
Cosegregation testing of family members is available for the following panels: EpilepsyNext, EpilepsyNext-Expanded, AutismNext, NeurodevelopmentNext

For Reflex or Concurrent Testing:

Test 1: _____ ☐ Reflex to ☐ Concurrent with Test 2: _____ ☐ Reflex to ☐ Concurrent with Test 3: _____

See Reflex or Concurrent Testing section of the Supplemental Information page.

Order	Test Name	Test Code	Description
Epilepsy			
☐	EpilepsyNext®	6864	124 genes for epilepsy
☐	EpilepsyNext-*Expanded*™	6865	>890 genes associated with seizures, primarily with neonatal to childhood onset
Hereditary Neuropathy			
☐	Familial transthyretin amyloidosis	1560	*TTR*

Order	Test Name	Test Code	Description
Neurodevelopmental Disorders			
☐	AutismNext®	6863	72 genes for non-syndromic autism spectrum disorders and/or intellectual disability
☐	Autism, macrocephaly	2106	*PTEN*
☐	Fragile X syndrome	4544	*FMR1* repeat expansion analysis and methylation studies
☐	NeurodevelopmentNext™	6861	202 genes known to cause developmental delay, intellectual disability and/or autism spectrum disorders

Neurocutaneous/Neuro-Oncology Disorders			
☐	Ataxia-telangiectasia	9014	*ATM*
☐	HHTNext®	8672	*ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4*
☐	Legius syndrome	5724	*SPRED1*
☐	Li-Fraumeni syndrome	2866	*TP53*
☐	Neurofibromatosis 1	5704	*NF1*

☐	Neurofibromatosis 2	9024	*NF2*
☐	Nevoid basal cell carcinoma syndrome/ Gorlin syndrome	5684	*PTCH1*
☐	Tuberous sclerosis complex	5904	*TSC1, TSC2*
☐	von Hippel-Lindau disease	2606	*VHL*

PULMONOLOGY

Congenital Central Hypoventilation Syndrome			
☐	Congenital central hypoventilation syndrome	1580	*PHOX2B* gene sequence
Cystic Fibrosis			
☐	*CFTR* gene sequence and deletion/duplication analysis	1007	☐ Report poly T/TG status

Primary Ciliary Dyskinesia			
☐	PCDNext®	8122	21 genes for primary ciliary dyskinesia ☐ Report poly T/TG status
Pulmonary Fibrosis			
☐	Telomere-related pulmonary fibrosis	8140	*TERT, TERC*
Respiratory Distress Syndrome			
☐	Surfactant dysfunction (respiratory distress syndrome)	8100	*ABCA3, SFTPB, SFTPC* gene sequence

VASCULAR

☐	HHTNext®	8672	*ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4*
☐	Marfan syndrome reflex to TAADNext	8783	*FBN1* reflex to TAADNext

☐	TAADNext®	8789	35 genes for thoracic aortic aneurysms

KNOWN VARIANT ANALYSIS (Please include a copy of relative's report)

Gene(s): _____ Variant(s) (c. and/or p.): _____ Relative Name: _____

Relationship to Relative: _____ Accession # (if tested at Ambry): _____

Positive control sample: ☐ will be provided ☐ already at Ambry ☐ not available

FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED

Both maternal and fetal specimens are required.

☐ 1260 MCC for fetal specimen or cord blood ☐ 1262 MCC Reference for maternal blood sample (No Charge)

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 (linked to QR code below).

Scan for current hereditary cancer panel gene content

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 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 bottom of page 5 for Maternal Cell Contamination sample submission test codes.

Testing on buccal swab samples is available for hereditary cancer testing, ExomeNext®, chromosomal microarray, epilepsy and neurodevelopental disorder panels, fragile X syndrome, hereditary neuropathy (familial transthyretin amyloidosis), and HHT next. 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 for details.

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.

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. Reflex testing is no longer available for Oncology orders.

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.

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.

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