

COMPLETE ENTIRE FORM TO AVOID DELAYS

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

COLLECTION DATE (REQUIRED)						
<p>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 ambrygen.com/specimen-requirements for details)						
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant						
Specimen ID			Medical Record #			
Collection Assistance: <input type="checkbox"/> Send saliva kit to patient <input type="checkbox"/> Send buccal kit to patient						
PRENATAL SAMPLES ONLY*						
Sample type: <input type="checkbox"/> Direct CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured amnio <input type="checkbox"/> POC <input type="checkbox"/> Cultured POC				Gestational age at sample collection		
* 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 2 for Maternal Cell Contamination sample submission test codes.						
INDICATION(S) FOR TESTING						
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			
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)			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)		Facility Name <input type="checkbox"/> Send invoice to facility address above		
Insurance Company		Policy #	HMO Auth #	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)
<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 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.</p> <p><input type="checkbox"/> 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.</p> <p>For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above.</p>						
<p>For NY Residents:</p> <p><input type="checkbox"/> 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.</p>						
Patient Signature (I agree to terms above):				Date:		

Known Variant Analysis Test Requisition Form

KNOWN VARIANT ANALYSIS (5555)		
Positive control: <input type="checkbox"/> Sent <input type="checkbox"/> To be sent <input type="checkbox"/> Not available <input type="checkbox"/> Available at Ambry, accession #:		
The following will be requested when ordering known variant analysis for a variant identified in an outside laboratory: 1. Proband report (mandatory) 2. Positive control (recommended; required for prenatal testing) ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence variant. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.	VARIANT TO BE TESTED	
	Gene 1	Variant (c. and/or p.)
	Gene 2	Variant (c. and/or p.)
	Gene 3	Variant (c. and/or p.)
	Gene 4	Variant (c. and/or p.)
PATIENT CLINICAL INFORMATION		
<input type="checkbox"/> Healthy <input type="checkbox"/> Affected/Symptomatic, age at diagnosis: Please list relevant clinical findings with ICD-10 codes:		
PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)		
Previously Detected Variant(s)	Gene Name	Testing Lab
Patient previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name	Date of Birth (MM/DD/YY)	Relation
FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED		
Both test codes required for fetal specimens		
<input type="checkbox"/> 1260 MCC for fetal specimen or cord blood <input type="checkbox"/> 1262 MCC Reference for maternal blood sample (No Charge)		

Supplemental Information

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 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 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 2 for Maternal Cell Contamination sample submission test codes.