Ambry Genetics®

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Microarray Parental Variant Study Requisition

PLEASE SUBMIT THIS COMPLETED FORM AND ANY SUPPLEMENTAL DOCUMENTATION WITH THE SPECIMEN.

The purpose of parental microarray follow-up studies for VUS variants detected on SNP array is to investigate the inheritance of the variant(s) of uncertain significance identified by chromosomal microarray analysis in this patient's child. While a whole genome technique may be used, only the presence or absence of the variant(s) identified in the proband will be reported. Additional incidental findings detected in the parental analysis, unrelated to the variant(s) detected in the proband, will NOT be reported, regardless of whether the incidental finding is pathogenic or clinically actionable. This assay cannot detect balanced chromosome rearrangements.

FAMILY STUDY PARTICIPANT INFORMATION

Name (Last, First, MI)	DOB (MM/DD/YY)	Relationship to Proband ☐Mother ☐Father	Gender ☐F ☐M

Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ☐Other:

Specimen Type(s) ☐Blood (EDTA preferred) ☐Saliva ☐DNA ☐Other:	Collection Date	Indication Variant Study

PROBAND INFORMATION (Previously tested relative)

Name (Last, First, MI)	DOB (MM/DD/YY)	Ambry Accession number

A sample from the proband's other parent is: ☐ Submitted simultaneously or already received at Ambry (other parent name & DOB: ______________________________)
☐ will not be submitted
☐ will be submitted soon with the estimated date of ____________________

FAMILY STUDIES TEST REQUEST	TEST CODE	ALTERATION
All VUS detected in proband (With the exception of VUS detected in autosomal recessive genes)	3005	See Proband Report

ORDERING PROVIDER

Ordering Physician	Address	City	State /Country	Zip

Phone	Fax/Email

CONTACT PERSON

Name (Last, First, MI)	Phone	Fax	Email

FAMILY STUDY PARTICIPANT CLINICAL HISTORY

PLEASE SUPPLY ANY AVAILABLE CLINIC NOTES (IF APPLICABLE)

☐Unaffected ☐ Affected (If yes, please complete sections below) Diagnosis/Suspected diagnosis: ______________________

PATERNAL CLINICAL HISTORY	MATERNAL CLINICAL HISTORY
☐ ______________________	☐ ______________________
☐ ______________________	☐ ______________________
☐ ______________________	☐ ______________________
☐ ______________________	☐ ______________________

Comments:

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. The patient has been informed that only the presence or absence of the VUS alteration(s) detected in the patient's child will be reported. If detected, incidental findings will NOT be reported (see above test description). I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this TRF is true to the best of my knowledge.

Signature Required for Processing Medical Professional Signature: Date:

Family Member Acknowledgement: I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the testing ordered prior to initiation, and I would like to proceed with test processing.

FOR NY RESIDENTS:

☐ I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.

Family Member/Guardian Signature:______________________ Date:____________

IMPORTANT INFORMATION

- Please provide documentation on diagnosis, clinic symptoms and family history if available.
- The current turnaround time for results is 1-2 months. Please contact Ambry Genetics if results are needed sooner and we will try our best to accommodate.