

# Test Requisition Form (TRF) - Preventive Care

**COMPLETE ENTIRE FORM TO AVOID DELAYS**

PATIENT INFORMATION			FAMILY HISTORY					
Name (Last, First, MI)			<input type="checkbox"/> None (maternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> None (paternal) <input type="checkbox"/> Paternal hx unknown					
DOB (MM/DD/YY)	Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Phone Number/Email	Relation to patient	Mat.	Pat.	Diagnosis	Dx age	
Address	City	State	Zip	<input type="checkbox"/>	<input type="checkbox"/>			
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish (Ashkenazi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:				<input type="checkbox"/>	<input type="checkbox"/>			
PATIENT HISTORY (Supply clinic notes when possible)			SPECIMEN INFORMATION* (For phlebotomy service select all services you are requesting)					
<input type="checkbox"/> No personal history of cancer PERSONAL HISTORY OF CANCER: Type(s): _____ Age(s) at Dx: _____ Breast pathology: ER: <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk   PR: <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk   HER2/neu: <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk Other pathology: Other clinical history:			Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Other: <input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant Collection Date   Specimen ID   MRN Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send kit to patient* <small>*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>					
*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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.								
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/Email		
Additional Medical Professional Name (Last, First) (Code)			Phone/Fax/Email		Additional Medical Professional Name (Last, First) (Code)		Phone/Fax/Email	
CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, 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. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambyr Genetics to facilitate the provision of pre-test genetic counseling services by a third party service, Informed DNA (unless otherwise noted), as required by the patient's insurance provider (unless this box is checked <input type="checkbox"/> ). Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.								
Signature Required for Processing   Medical Professional Signature:						Date:		
INDICATIONS FOR TESTING (Check all that apply)								
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Family history <input type="checkbox"/> Positive or normal control <input type="checkbox"/> Other						ICD-10 code(s):		
TEST REQUESTED								
If this TRF is sent to Ambyr 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.								
For multiple test orders, testing will be run concurrently (multiple tests initiated at the same time) unless otherwise specified. To order reflexive testing (second test starts pending first test outcome), please clearly indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported out to the clinician, and the requested second test will be canceled; all other findings will automatically reflex (including VUS).						Notes:		
<b>Multi-Gene Orders</b> For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history: <input type="checkbox"/> Hereditary breast and ovarian cancer (BRCA1/2) <input type="checkbox"/> Lynch syndrome/HNPCC (MLH1, MSH2, MSH6, PMS2, EPCAM) <input type="checkbox"/> Testing is clinically indicated for other gene(s): <input type="checkbox"/> None of the above To complete your order, please select or write-in a test option below: <input type="checkbox"/> CancerNext (8824) <input type="checkbox"/> Other: Test Code: _____ Test Name: _____			<b>Single Gene Orders</b> <input type="checkbox"/> BRCA1/2 gene sequencing and deletion/duplication analysis (8838) Other: Test Code(s): _____ Gene/Test Name(s): _____ <b>Single Site Analysis (SSA) (Include relative report)</b> Gene(s): _____ Mutation(s): _____ Previously Tested Relative (name): _____ Relationship to Relative: _____ Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambyr <input type="checkbox"/> not available					
For more information about our other hereditary cancer panel options, please visit <a href="http://ambrygen.com/hereditary-cancer-panels">ambrygen.com/hereditary-cancer-panels</a> . For more information about single gene testing options, please visit <a href="http://ambrygen.com/hereditary-cancer-single-gene-tests">ambrygen.com/hereditary-cancer-single-gene-tests</a> .								
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				
<b>Out Of Pocket:</b> Ambyr Genetics will start testing immediately. We will attempt to contact the patient if: <input type="checkbox"/> Out-of-pocket amount is greater than \$100 (default) <input type="checkbox"/> There is any out-of-pocket amount <input type="checkbox"/> Do not initiate testing until patient is contacted and approves payment terms regarding out-of-pocket Patient agrees to contact regarding out-of-pocket amount by: <input type="checkbox"/> Email <input type="checkbox"/> Phone (includes texts) - confirm mobile # _____				Contact Name		E-mail/Fax		
				<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambyr Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)		
<b>Patient Acknowledgement:</b> 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 Ambyr Genetics Corporation (Ambyr), authorize Ambyr 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 Ambyr money received from my health insurance company.								
<b>For patient payment by credit card:</b> I hereby authorize Ambyr Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambyr's E.P.I.C. Program, please provide the total annual gross household income: \$ _____ and the number of family members in the household supported by the listed income: _____. I authorize Ambyr Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.								
FOR NY RESIDENTS:								
<input type="checkbox"/> I am a New York resident and I give Ambyr Genetics permission to store my sample for longer than 60 days. <b>NOTE:</b> If left blank, consent is interpreted as "NO".								
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:						Date:		

## Supplemental Information

### Ordering Instructions:

Our ordering process helps confirm that testing for one or more of the following genes is clinically indicated: *BRCA1*, *BRCA2*, *EPCAM*, *MLH1*, *MSH2*, *MSH6*, and *PMS2*.

**If you are ordering a multi-gene test**, please first select a clinically indicated condition and complete your order by selecting a multi-gene order.

Please indicate if your patient meets clinical and/or insurance testing criteria, or if the testing is otherwise clinically indicated for one or more of the following conditions:

- Hereditary breast and ovarian cancer (*BRCA1/2*)
- Lynch syndrome/HNPCC (*MLH1*, *MSH2*, *MSH6*, *PMS2*, *EPCAM*)

If testing is not clinically indicated for your patient for any of the listed options, please either fill in the other gene(s) option or select "none of the above".

To complete your multi-gene order, please select the CancerNext option and/or select "other" and enter the appropriate test code(s)/test name(s).

**For single gene orders**, please either select the *BRCA1/2* testing option or enter the desired gene(s) and/or test name(s), as well as the relevant test code in the single gene orders section.

### Example

For a CancerNext order, when *BRCA1/2* testing is clinically indicated for the patient:

#### Multi-Gene Orders

For multi-gene orders, first select which of the following conditions is clinically indicated based on the patient's personal and/or family history:

- Hereditary breast and ovarian cancer (*BRCA1/2*)
- Lynch syndrome/HNPCC (*MLH1*, *MSH2*, *MSH6*, *PMS2*, *EPCAM*)
- Testing is clinically indicated for other gene(s):
- None of the above

To complete your order, please select or write-in a test option below:

- CancerNext (8824)
- Other: Test Code: \_\_\_\_\_ Test Name: \_\_\_\_\_

For *BRCA1/2* testing only:

#### Single Gene Orders

- BRCA1/2* gene sequencing and deletion/duplication analysis (8838)

Other: Test Code(s): \_\_\_\_\_ Gene/Test Name(s): \_\_\_\_\_

#### Single Site Analysis (SSA) (Include relative report)

Gene(s): \_\_\_\_\_ Mutation(s): \_\_\_\_\_

Previously Tested Relative (name): \_\_\_\_\_

Relationship to Relative: \_\_\_\_\_

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

### CancerNext includes the following 34 genes associated with hereditary cancer:

<i>APC</i>	<i>ATM</i>	<i>BARD1</i>	<i>BRCA1</i>	<i>BRCA2</i>	<i>BRIP1</i>	<i>BMPRIA</i>	<i>CDH1</i>	<i>CDK4</i>
<i>CDKN2A</i>	<i>CHEK2</i>	<i>DICER1</i>	<i>EPCAM</i>	<i>GREM1</i>	<i>HOXB13</i>	<i>MLH1</i>	<i>MRE11A</i>	<i>MSH2</i>
<i>MSH6</i>	<i>MUTYH</i>	<i>NBN</i>	<i>NF1</i>	<i>PALB2</i>	<i>PMS2</i>	<i>POLD1</i>	<i>POLE</i>	<i>PTEN</i>
<i>RAD50</i>	<i>RAD51C</i>	<i>RAD51D</i>	<i>SMAD4</i>	<i>SMARCA4</i>	<i>STK11</i>	<i>TP53</i>		