Ambry Genetics®
A Konica Minolta Company

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AmbryScore™ SUPPLEMENTAL ORDERING FORM

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	DOB (MM/DD/YY)

OPT-IN TO AMBRYSCORE

☐ Add AmbryScore to multigene panel testing*

** AmbryScore can only be added to orders for BreastNext, OvaNext, CancerNext, CancerNext-Expanded, and CustomNext-Cancer*

Eligibility Criteria

☐ I confirm that my patient meets all of the below eligibility criteria for AmbryScore.
Note: If this box is not checked, AmbryScore will not be calculated.

1. Non-Ashkenazi Jewish, Caucasian
2. Female biological sex
3. Age 18-84 years
4. No personal history of cancer (excluding non-melanoma skin cancer), atypical hyperplasia, or LCIS
5. No family history of a mutation in a breast cancer susceptibility gene^

^Breast cancer genes: ATM, BARD1, BLM (if tested), BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FANCC (if tested), MRE11A, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53

BREAST CANCER RISK MODEL INFORMATION (Required for AmbryScore calculation)

Additional Patient Information

Height: ___ft ____in Weight: _____ lbs

Age at first menstruation: _____

Menopausal Status: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menopausal Age of menopause onset (if applicable): _____

Number of live births: _____ Age at first child's birth (if applicable):_____

Has the patient ever used Hormone Replacement Therapy (HRT)? ☐ No ☐ Yes
If yes, treatment type: ☐ Combined ☐ Estrogen only
If yes, select one of the following:
☐ Currently using HRT, started _____ years ago; intended to use for _____ more years
☐ Past HRT user, stopped _____ years ago; used for _____ years

Biopsy History:
☐ No prior biopsy/no proliferative disease ☐ Prior biopsy, result unknown ☐ Hyperplasia (not atypical)
☐ Atypical hyperplasia ☐ Lobular carcinoma in situ (LCIS)

Mammographic Density:
Has the patient had her breast density assessed? ☐ No ☐ Yes
If yes, complete one of the following:
Volpara® Volumetric Density: _____%
VAS Percentage Density: _____%
BI-RADS® ATLAS Density (select one of the following):
☐ Almost entirely fatty ☐ Scattered fibroglandular density ☐ Heterogeneously dense ☐ Extremely dense ☐ Unknown

Female Relatives

Number of daughters: _____ Number of sisters: _____
Number of maternal aunts (mother's sisters): _____ Number of paternal aunts (father's sisters): _____

Additional family history information provided in the test requisition form and/or any chart notes/pedigrees will also be incorporated into the AmbryScore calculation.