Pulmonology Test Requisition Form - Page 1 of 2

COMPLETE ENTIRE FORM TO AVOID DELAYS

Ambry Genetics®
A Konica Minolta Company
Aliso Viejo, CA 92656 USA
Toll Free: 866.262.7943 | Fax: 949.900.5501 | ambrygen.com

PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Date of Death (If applicable)	Phone Number/Email

Address City State Zip	Biological Sex ☐F ☐M	Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ☐Other:

SPECIMEN INFORMATION* (For phlebotomy service, select all services you are requesting)

Type(s) ☐Blood (EDTA preferred) ☐Saliva ☐DNA ☐Cord Blood** ☐Other**: ☐Personal history of allogenic bone marrow or peripheral stem cell transplant

Collection Date	Specimen ID	Medical Record #

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.
***If submitting Cord Blood or a fetal specimen, please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.*

Phlebotomy Services Request: ☐Phlebotomy draw ☐Insurance preverification first ☐Send kit to patient^
^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 patient management be changed depending on the test results? ☐ Yes ☐ No

PATIENT HISTORY ☐ No personal history of pulmonology disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date: Upcoming procedure date:

Reasons for Testing

☐ Positive newborn screen
☐ Infections: _____
☐ Sweat chloride: _____mmol/L
☐ Sweat chloride: ☐<40 ☐ 40-60 ☐ >60
☐ CBAVD
☐ Meconium ileus
☐ Pancreatic insufficiency IRT level: _____
☐ Respiratory distress, explain: _____
☐ Respiratory assistance devices: _____
☐ Ultrasound findings: _____
☐ Other: _____

Relevant lab results (include copies if possible)

FAMILY HISTORY

☐ None (maternal) ☐ Maternal hx unknown ☐ None (paternal) ☐ Paternal hx unknown

Relationship to patient_____ ☐ Maternal ☐ Paternal
Diagnosis_____ Dx age _____
Relationship to patient_____ ☐ Maternal ☐ Paternal
Diagnosis_____ Dx age _____

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

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

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. 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. My signature applies to the attached letter of medical necessity (unless this box is checked ☐).

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 #

Out Of Pocket:
Ambry Genetics will start testing immediately. We will attempt to contact the patient if:
☐ Out-of-pocket amount is greater than $100 (default) ☐ There is any out-of-pocket amount
☐ 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:
☐ Email ☐ Phone (includes texts) - confirm mobile # _____

☐ GRATIS (Check for pre-approved gratis testing)

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*
Address
Contact Name
Phone Number E-mail/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.
For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambry's Patient Assistance 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 Ambry 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: ☐ 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".

Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Date:

Ambry Genetics®
A Konica Minolta Company
Aliso Viejo, CA 92656 USA | Toll Free: 866.262.7943 | Fax: 949.900.5501 | ambrygen.com

REQUIRED ORDERING CHECKLIST

- ☐ Clinic notes (with pedigree if available)
- ☐ ICD-10 code(s)
- ☐ Clinician & patient signatures
- ☐ Insurer-specific forms (i.e. ABN), if applicable
- ☐ Front/back copy of insurance card(s)

Pulmonology Test Requisition Form - Page 2 of 2

Please check the box next to the test(s) being ordered below. All tests include gene sequence and deletion/duplication analyses, unless otherwise indicated.
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.

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).

Check to order	Test Name	Test Code	Description
Congenital Central Hypoventilation Syndrome			
☐	Congenital central hypoventilation syndrome	1580	*PHOX2B* gene sequence
Cystic Fibrosis			
☐	508 FIRST	1002	☐ Report poly T/TG status Test for *CFTR* deltaF508 mutation with reflex to *CFTR* gene sequence and deletion/duplication
☐	*CFTR* gene sequence and deletion/duplication analysis	1007	☐ Report poly T/TG status

SINGLE SITE ANALYSIS (Please include a copy of relative's report)

Gene(s): _____ Mutation(s): _____

Relative Name: _____

Relationship to Relative: _____

Accession # (If tested at Ambry): _____

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

FOR PRENATAL SPECIMENS OR CORD BLOOD: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)

- ☐ 1260 MCC for fetal specimen or cord blood (run concurrently with test)
- ☐ 1262 MCC Reference for maternal blood sample (No Charge)

Check to order	Test Name	Test Code	Description
Primary Ciliary Dyskinesia			
☐	PCDNext	8122	☐ Report poly T/TG status 21 genes for primary ciliary dyskinesia
Pulmonary Fibrosis			
☐	Telomere-related pulmonary fibrosis	8140	*TERT, TERC*
Respiratory Distress Syndrome			
☐	Surfactant dysfunction panel	8100	*ABCA3, SFTPB, SFTPC* gene sequence
Clinical Genomics			
☐	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)
☐	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
☐	Parental targeted microarray	5495	Paid option. Only available following SNP Array (5490) completed at Ambry. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambry: _____
☐	ExomeNext-*Proband*	9993	Proband only exome sequencing Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Proband* plus mtDNA^	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Trio*	9995	Trio exome sequencing Candidate (Novel) Genetic Etiologies: ☐ Opt-out Secondary Findings^^: ☐ Opt-out
☐	ExomeNext-*Trio* plus mtDNA^	9996	Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: ☐ Opt-out Secondary Findings^^: ☐ Opt-out
Order through AP*	ExomeNext-*Select*	9500	Rapid Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: ☐ Opt-out Secondary Findings^^: ☐ Opt-out

^Mitochondrial (mtDNA) testing cannot be performed on saliva samples.
^^Secondary Findings: If box is left unchecked, the ACMG recommended list of Secondary Findings will be reported. Secondary Findings are not available for ExomeNext-Select orders.
**AP is AmbryPort, our online portal ambrygen.com/ap*

If ordering ExomeNext/ExomeNext-Rapid, please complete:
Secondary Findings Report: Check below to order the ACMG Recommended List of secondary findings. If neither box is checked secondary findings will not be reported. Secondary findings results are issued in a separate report. (For expanded secondary findings options and pricing please complete the "ExomeNext Expanded Secondary Findings Request Form" and submit with sample).

- ☐ Yes: I choose to receive the ACMG Recommended List of secondary findings
- ☐ No: I choose to decline the ACMG Recommended List of secondary findings