Sudden Death Test Requisition Form - Page 1 of 2

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

COMPLETE ENTIRE FORM TO AVOID DELAYS

PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Date of Death (MM/DD/YY)	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.*

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 RESULTS RECIPIENTS

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
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 Ambry 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 ☐). 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:

☐ 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:

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Patient Name: _____ DOB: _____

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)

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INDICATION(S) FOR TESTING

☐ Diagnostic ☐ Family history ☐ Positive or normal control ☐ Other:_____

ICD-10 code(s): _____

Will patient management be changed depending on the test results? ☐ Yes ☐ No

PATIENT HISTORY ☐ No personal history of cardiovascular disease ☐ No personal history of neurological disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE

CARDIOVASCULAR MEDICAL HISTORY

Sudden cardiac arrest ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

Episodes:_____ Age first incident:_____

Syncope ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

History of cardiomyopathy ☐ Y ☐ N Age at dx:_____

☐ HCM ☐ DCM ☐ ARVC ☐ LVNC ☐ RCM

☐ Other cardiomyopathy Types:_____

History of Arrhythmia ☐ Y ☐ N Age at dx: _____

☐ Long QT ☐ Short QT ☐ Brugada ☐ CPVT ☐ ARVC

☐ Other arrhythmia Types: _____

Other features/syndromes

☐ Clinical diagnosis of Marfan Syndrome

☐ Aortic Aneurysm/Dilation Age at dx:_____

☐ Other Aneurysm Location:_____ Age at dx:_____

☐ Aortic/Vascular Dissection Location:_____Age at dx:_____

☐ Arterial tortuosity ☐ BAV ☐ MVP

☐ Congenital Heart Defect Type:_____

☐ Ectopia lentis ☐ Myopia ☐ Marfanoid habitus

☐ Pectus deformity Type:_____

☐ Scoliosis ☐ Joint Hypermobility ☐ Joint contractures

☐ Pneumothorax ☐ Craniosynostosis

☐ Facial clefting, Type : _____

☐ Xanthoma(s) ☐ Epistaxis (nosebleeds) ☐ Telangiectasia

☐ AVM Location: _____

☐ Amyloidosis Age at dx: _____

☐ Neuromuscular disease Specify: _____

☐ Hearing Loss Describe: _____

☐ Genetic syndrome Specify: _____

☐ Other Specify:_____

NEUROLOGICAL MEDICAL HISTORY

Seizure History ☐ N/A Age at first unprovoked seizure: _____

Was this patient diagnosed with an epilepsy syndrome? ☐ yes ☐ no ☐ unknown

If yes, please specify: _____

Prior Testing and Procedures:

FAMILY HISTORY

Mother: ☐ Unaffected ☐ Affected, list symptoms/dx:_____

_____ Dx age:_____

Father: ☐ Unaffected ☐ Affected, list symptoms/dx:_____

_____ Dx age:_____

Relationship to patient:_____ ☐ Maternal ☐ Paternal

Diagnosis:_____ Dx age:_____

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
Arrhythmia			
☐	RhythmNext	8900	36 genes for long QT syndrome, Brugada syndrome, and other inherited arrhythmias
☐	CPVTNext	8902	6 genes for catecholaminergic polymorphic ventricular tachycardia
Cardiomyopathy			
☐	HCMNext	8936	27 genes for hypertrophic cardiomyopathy
☐	DCMNext	8884	36 genes for dilated cardiomyopathy
☐	ARVCNext	8904	9 genes for arrhythmogenic right ventricular cardiomyopathy
☐	LVNCNext	8906	8 genes for left ventricular non-compaction
☐	CMNext with *TTN*	8886	55 genes for hereditary cardiomyopathy
Cardiomyopathy and Arrhythmia			
☐	CardioNext with *TTN*	8911	85 genes for hereditary cardiomyopathies and arrhythmias
Familial Hypercholesterolemia			
☐	FHNext	8680	4 genes (*APOB, LDLR, LDLRAP1, PCSK9*)

☐ Check this box if you would like to have the *SLC01B1* c.521T>C polymorphism reported, which has been associated in medical literature with statin-induced myopathies

Check to order	Test Name	Test Code	Description
Other Cardiac Findings			
☐	TAADNext	8789	22 genes for thoracic aortic aneurysms/ dissections, Marfan syndrome, and related disorders
Seizures/Epilepsy			
☐	EpilepsyNext	7019	100 genes for epilepsy

ADDITIONAL TESTS

Test: _____ Test code: _____

Test: _____ Test code: _____

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)