

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 <input type="checkbox"/> F <input type="checkbox"/> M	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:
SPECIMEN INFORMATION* (For phlebotomy service, select all services you are requesting)					
Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Cord Blood** <input type="checkbox"/> Other**:			<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant		
Collection Date	Specimen ID		Medical Record #		
<p>*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.</p> <p>**If submitting Cord Blood or a fetal specimen, please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.</p>					
ORDERING PHYSICIAN/SENDING FACILITY (Each listed person will receive a copy of the report)					
Facility Name (Facility Code)		Address	City	State/Country	Zip
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					
<p>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 <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.</p>					
Signature Required for Processing Medical Professional Signature:				Date:	
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		
Out Of Pocket: Ambry 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		
			Phone Number	E-mail/Fax	
<input type="checkbox"/> GRATIS (Check for pre-approved gratis testing)			<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)
<p>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.</p> <p>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.</p>					
FOR NY RESIDENTS:					
<input type="checkbox"/> 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:	

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)

Sudden Death Test Requisition Form - Page 2 of 2

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			
<input type="checkbox"/>	RhythmNext	8900	36 genes for long QT syndrome, Brugada syndrome, and other inherited arrhythmias
<input type="checkbox"/>	CPVTNext	8902	6 genes for catecholaminergic polymorphic ventricular tachycardia
Cardiomyopathy			
<input type="checkbox"/>	HCMNext	8936	27 genes for hypertrophic cardiomyopathy
<input type="checkbox"/>	DCMNext	8884	36 genes for dilated cardiomyopathy
<input type="checkbox"/>	ARVCNext	8904	9 genes for arrhythmogenic right ventricular cardiomyopathy
<input type="checkbox"/>	LVNCNext	8906	8 genes for left ventricular non-compaction
<input type="checkbox"/>	CMNext with TTN	8886	55 genes for hereditary cardiomyopathy
Cardiomyopathy and Arrhythmia			
<input type="checkbox"/>	CardioNext with TTN	8911	85 genes for hereditary cardiomyopathies and arrhythmias
Familial Hypercholesterolemia			
<input type="checkbox"/>	FHNext	8680	4 genes (APOB, LDLR, LDLRAP1, PCSK9)
<input type="checkbox"/> 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			
<input type="checkbox"/>	TAADNext	8789	22 genes for thoracic aortic aneurysms/dissections, Marfan syndrome, and related disorders
Seizures/Epilepsy			
<input type="checkbox"/>	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: <input type="checkbox"/> Will be provided <input type="checkbox"/> Already at Ambry <input type="checkbox"/> Not available			
FOR PRENATAL SPECIMENS OR CORD BLOOD: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)			
<input type="checkbox"/>	1260	MCC for fetal specimen or cord blood (run concurrently with test)	
<input type="checkbox"/>	1262	MCC Reference for maternal blood sample (No Charge)	