

COMPLETE ENTIRE FORM TO AVOID DELAYS

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 <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)					
<input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> Buccal Swab* <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 #		
<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 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. *Only for Fragile X syndrome and chromosomal microarray.</small>					
Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PATIENT HISTORY <input type="checkbox"/> No personal history of neurological disease					
PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date:			Upcoming procedure date:		
Reasons for Testing:					
Birth and Neonatal History <input type="checkbox"/> N/A Gestational age at birth: _____ Birth weight: _____ Head circumference at birth (if available): _____ Developmental History <input type="checkbox"/> N/A Developmental delay: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Type of delay (choose all that apply): <input type="checkbox"/> motor <input type="checkbox"/> language <input type="checkbox"/> global Intellectual disability: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Regression or plateau: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder? <input type="checkbox"/> yes <input type="checkbox"/> no Seizure History <input type="checkbox"/> N/A Age at first unprovoked seizure: _____ Has this patient been diagnosed with an epilepsy syndrome? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown If yes, please specify: _____ Other History <input type="checkbox"/> N/A Hypo-/hyperpigmentation: <input type="checkbox"/> yes <input type="checkbox"/> no Telangiectasias: <input type="checkbox"/> yes <input type="checkbox"/> no Other skin abnormality, type: _____ Brain tumor, type: _____ Nerve tumor, type: _____ Other tumor, type: _____			Other Features (choose all that apply) <input type="checkbox"/> Ataxia <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Psychiatric disorder <input type="checkbox"/> Dysmorphic features <input type="checkbox"/> Microcephaly <input type="checkbox"/> Spasticity <input type="checkbox"/> Hearing disorder <input type="checkbox"/> Migraine <input type="checkbox"/> Vision disorder <input type="checkbox"/> Hypotonia <input type="checkbox"/> Movement disorder Prior Testing		
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, 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 <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:	
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)
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: <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: Patient Signature				Date:	

Neurology Test Requisition Form - Page 2 of 4

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.

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)

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	Check to order	Test Name	Test Code	Description
Comprehensive Testing (Required: completed CustomNext-Neuro ordering form on page 3)				Migraine			
<input type="checkbox"/>	CustomNext-Neuro	9540	Up to 196 gene custom neurology test	<input type="checkbox"/>	Familial hemiplegic migraine	7035	ATP1A2, CACNA1A, PRRT2, SCN1A <input type="checkbox"/> Check if parental samples are included
Epilepsy				Neurodevelopmental Disorders			
<input type="checkbox"/>	EpiRapid <i>blood only, no saliva</i>	7033	16 epilepsy genes with treatment associations	<input type="checkbox"/>	Rett syndrome	2026	MECP2
<input type="checkbox"/>	EpiRapid reflex to EpilepsyNext <i>blood only, no saliva</i>	7034	16 epilepsy genes with treatment associations, reflex to 100 genes for epilepsy	<input type="checkbox"/>	AutismNext	7024	48 genes for syndromic and non-syndromic ASDs <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpiFirst-Fever	7011	13 genes for febrile seizures <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Autism, macrocephaly	2106	PTEN
<input type="checkbox"/>	EpiFirst-Focal	7017	11 genes for non-lesional focal epilepsy <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Fragile X syndrome	4544	FMR1 repeat expansion analysis and methylation studies
<input type="checkbox"/>	EpiFirst-IS	7013	17 genes for infantile spasms <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	IDNext	7027	140 genes for syndromic and non-syndromic ID <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	EpilepsyNext	7019	100 genes for epilepsy <input type="checkbox"/> Check if parental samples are included	<input type="checkbox"/>	Neurodevelopment-Expanded	7028	196 genes for ID, ASDs, and epilepsy <input type="checkbox"/> Check if parental samples are included
<input type="checkbox"/>	Neurodevelopment-Expanded	7028	196 genes for epilepsy, ID, ASDs <input type="checkbox"/> Check if parental samples are included	Hereditary Neuropathy			
Clinical Genomics				<input type="checkbox"/>	Familial transthyretin amyloidosis	1560	TTR
<input type="checkbox"/>	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)	Neurocutaneous/Neuro-Oncology Disorders			
<input type="checkbox"/>	SNP Array	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)	<input type="checkbox"/>	Ataxia-telangiectasia	9014	ATM
<input type="checkbox"/>	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: _____	<input type="checkbox"/>	BrainTumorNext	8847	27 genes for brain tumors
<input type="checkbox"/>	ExomeNext-Proband	9993	Proband only exome sequencing Secondary Findings ^{^^} : <input type="checkbox"/> Opt-out	<input type="checkbox"/>	HHTNext	8672	ACVRL1, ENG, SMAD4, GDF2, RASA1
<input type="checkbox"/>	ExomeNext-Proband plus mtDNA [^]	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings ^{^^} : <input type="checkbox"/> Opt-out	<input type="checkbox"/>	Legius syndrome	5724	SPRED1
<input type="checkbox"/>	ExomeNext-Trio	9995	Trio exome sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings ^{^^} : <input type="checkbox"/> Opt-out	<input type="checkbox"/>	Li-Fraumeni syndrome	2866	TP53
<input type="checkbox"/>	ExomeNext-Trio plus mtDNA [^]	9996	Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings ^{^^} : <input type="checkbox"/> Opt-out	<input type="checkbox"/>	Neurofibromatosis 1	5704	NF1
<input type="checkbox"/>	Order through AP*	9500	Up to 500 gene custom exome sequencing test	<input type="checkbox"/>	Neurofibromatosis 2	9024	NF2
*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				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)			

FAMILY HISTORY (Completion of this section is required for order including parental samples. If available, please also submit a 3-generation pedigree)

Relative	Name	DOB	Affected status*	Samples included?	Secondary findings**
			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/> opt in <input type="checkbox"/> opt out
			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/> opt in <input type="checkbox"/> opt out

*If affected, please list symptoms and age at diagnosis: _____

** If reflexing to whole exome sequencing, please indicate opt-in or opt-out of the ACMG Secondary Findings minimum list

CustomNext-Neuro (9540) Ordering Form - Page 3 of 4

(This form is ONLY required if ordering CustomNext-Neuro, test code 9540)

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

CUSTOMIZE YOUR PANEL

To create your own panel, add all desired genes below **OR** select one of the following multi-gene tests and add or remove all desired genes below. All genes include sequencing and deletion/duplication analysis.

- | | | |
|---|--|---|
| <input type="checkbox"/> EpiFirst-Fever: 13 genes for febrile seizures | <input type="checkbox"/> EpilepsyNext: 100 genes for epilepsy | <input type="checkbox"/> IDNext: 140 genes for intellectual disability |
| <input type="checkbox"/> EpiFirst-IS: 17 genes for infantile spasms | <input type="checkbox"/> AutismNext: 48 genes for autism spectrum disorder | <input type="checkbox"/> Neurodevelopment-Expanded: All 196 genes in CustomNext-Neuro |
| <input type="checkbox"/> EpiFirst-Focal: 11 genes for non-lesional focal epilepsy | | |

A list of genes for each multi-gene test is available on ambrygen.com

- Rett/Angelman syndrome: 22 genes associated with Rett syndrome, Angelman syndrome, and phenocopies (ARX, ATRX, CDKL5, CNTNAP2, DYRK1A, EHMT1, FOXG1, IQSEC2, MBD5, MECP2, MEF2C, NRXN1, PCDH19, PNKP, SATB2, SHANK3, SLC2A1, SLC9A6, STXB1, TCF4, UBE3A, ZEB2)
- Batten disease: 13 genes associated with NCLs, or Batten disease (ATP13A2, CLN3, CLN5, CLN6, CLN8, CTSD, CTSF, DNAJC5, GRN, KCTD7, MFSD8, PPT1, TPP1)

CUSTOM GENE SELECTION (Check "+" to add and "-" to remove)

+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-	+	GENE	-
<input type="checkbox"/>	ABCD1	<input type="checkbox"/>	<input type="checkbox"/>	CREBBP	<input type="checkbox"/>	<input type="checkbox"/>	GNAO1	<input type="checkbox"/>	<input type="checkbox"/>	MAOA	<input type="checkbox"/>	<input type="checkbox"/>	PNPO	<input type="checkbox"/>	<input type="checkbox"/>	SMARCA2	<input type="checkbox"/>
<input type="checkbox"/>	ACSL4	<input type="checkbox"/>	<input type="checkbox"/>	CRH	<input type="checkbox"/>	<input type="checkbox"/>	GOSR2	<input type="checkbox"/>	<input type="checkbox"/>	MBD5	<input type="checkbox"/>	<input type="checkbox"/>	POGZ	<input type="checkbox"/>	<input type="checkbox"/>	SMARCA4	<input type="checkbox"/>
<input type="checkbox"/>	ADNP	<input type="checkbox"/>	<input type="checkbox"/>	CSTB	<input type="checkbox"/>	<input type="checkbox"/>	GPC3	<input type="checkbox"/>	<input type="checkbox"/>	MECP2	<input type="checkbox"/>	<input type="checkbox"/>	POLG	<input type="checkbox"/>	<input type="checkbox"/>	SMARCB1	<input type="checkbox"/>
<input type="checkbox"/>	ALDH7A1	<input type="checkbox"/>	<input type="checkbox"/>	CTCF	<input type="checkbox"/>	<input type="checkbox"/>	GRIA3	<input type="checkbox"/>	<input type="checkbox"/>	MED12	<input type="checkbox"/>	<input type="checkbox"/>	PORCN	<input type="checkbox"/>	<input type="checkbox"/>	SMC1A	<input type="checkbox"/>
<input type="checkbox"/>	ALG13	<input type="checkbox"/>	<input type="checkbox"/>	CTSD	<input type="checkbox"/>	<input type="checkbox"/>	GRIN1	<input type="checkbox"/>	<input type="checkbox"/>	MED23	<input type="checkbox"/>	<input type="checkbox"/>	PPT1	<input type="checkbox"/>	<input type="checkbox"/>	SMC3	<input type="checkbox"/>
<input type="checkbox"/>	ANKRD11	<input type="checkbox"/>	<input type="checkbox"/>	CTSF	<input type="checkbox"/>	<input type="checkbox"/>	GRIN2A	<input type="checkbox"/>	<input type="checkbox"/>	MEF2C	<input type="checkbox"/>	<input type="checkbox"/>	PQBP1	<input type="checkbox"/>	<input type="checkbox"/>	SMS	<input type="checkbox"/>
<input type="checkbox"/>	AP1S2	<input type="checkbox"/>	<input type="checkbox"/>	CUL4B	<input type="checkbox"/>	<input type="checkbox"/>	GRIN2B	<input type="checkbox"/>	<input type="checkbox"/>	MFSD8	<input type="checkbox"/>	<input type="checkbox"/>	PRICKLE1	<input type="checkbox"/>	<input type="checkbox"/>	SNAP25	<input type="checkbox"/>
<input type="checkbox"/>	AP4B1	<input type="checkbox"/>	<input type="checkbox"/>	DCX	<input type="checkbox"/>	<input type="checkbox"/>	GRN	<input type="checkbox"/>	<input type="checkbox"/>	MID1	<input type="checkbox"/>	<input type="checkbox"/>	PRRT2	<input type="checkbox"/>	<input type="checkbox"/>	SPTAN1	<input type="checkbox"/>
<input type="checkbox"/>	ARHGEF9	<input type="checkbox"/>	<input type="checkbox"/>	DDX3X	<input type="checkbox"/>	<input type="checkbox"/>	HCN1	<input type="checkbox"/>	<input type="checkbox"/>	NDP	<input type="checkbox"/>	<input type="checkbox"/>	PTCHD1	<input type="checkbox"/>	<input type="checkbox"/>	ST3GAL3	<input type="checkbox"/>
<input type="checkbox"/>	ARID1B	<input type="checkbox"/>	<input type="checkbox"/>	DEPDC5	<input type="checkbox"/>	<input type="checkbox"/>	HDAC8	<input type="checkbox"/>	<input type="checkbox"/>	NDUFA1	<input type="checkbox"/>	<input type="checkbox"/>	PTEN	<input type="checkbox"/>	<input type="checkbox"/>	STX1B	<input type="checkbox"/>
<input type="checkbox"/>	ARX	<input type="checkbox"/>	<input type="checkbox"/>	DHCR7	<input type="checkbox"/>	<input type="checkbox"/>	HNRNPU	<input type="checkbox"/>	<input type="checkbox"/>	NHLRC1	<input type="checkbox"/>	<input type="checkbox"/>	PTPN11	<input type="checkbox"/>	<input type="checkbox"/>	STXB1	<input type="checkbox"/>
<input type="checkbox"/>	ATP13A2	<input type="checkbox"/>	<input type="checkbox"/>	DLG3	<input type="checkbox"/>	<input type="checkbox"/>	HOXA1	<input type="checkbox"/>	<input type="checkbox"/>	NHS	<input type="checkbox"/>	<input type="checkbox"/>	PURA	<input type="checkbox"/>	<input type="checkbox"/>	SYN1	<input type="checkbox"/>
<input type="checkbox"/>	ATPIA2	<input type="checkbox"/>	<input type="checkbox"/>	DNAJC5	<input type="checkbox"/>	<input type="checkbox"/>	HPRT1	<input type="checkbox"/>	<input type="checkbox"/>	NIPBL	<input type="checkbox"/>	<input type="checkbox"/>	RAB39B	<input type="checkbox"/>	<input type="checkbox"/>	SYNGAP1	<input type="checkbox"/>
<input type="checkbox"/>	ATP7A	<input type="checkbox"/>	<input type="checkbox"/>	DNM1	<input type="checkbox"/>	<input type="checkbox"/>	HUWE1	<input type="checkbox"/>	<input type="checkbox"/>	NLGN3	<input type="checkbox"/>	<input type="checkbox"/>	RAD21	<input type="checkbox"/>	<input type="checkbox"/>	SZT2	<input type="checkbox"/>
<input type="checkbox"/>	ATRX	<input type="checkbox"/>	<input type="checkbox"/>	DYNC1H1	<input type="checkbox"/>	<input type="checkbox"/>	IDS	<input type="checkbox"/>	<input type="checkbox"/>	NLGN4X	<input type="checkbox"/>	<input type="checkbox"/>	RAI1	<input type="checkbox"/>	<input type="checkbox"/>	TBC1D24	<input type="checkbox"/>
<input type="checkbox"/>	BRWD3	<input type="checkbox"/>	<input type="checkbox"/>	DYRK1A	<input type="checkbox"/>	<input type="checkbox"/>	IQSEC2	<input type="checkbox"/>	<input type="checkbox"/>	NRXN1	<input type="checkbox"/>	<input type="checkbox"/>	RPL10	<input type="checkbox"/>	<input type="checkbox"/>	TBL1XR1	<input type="checkbox"/>
<input type="checkbox"/>	CA8	<input type="checkbox"/>	<input type="checkbox"/>	EEF1A2	<input type="checkbox"/>	<input type="checkbox"/>	KAT6A	<input type="checkbox"/>	<input type="checkbox"/>	NSD1	<input type="checkbox"/>	<input type="checkbox"/>	RPS6KA3	<input type="checkbox"/>	<input type="checkbox"/>	TBR1	<input type="checkbox"/>
<input type="checkbox"/>	CACNA1A	<input type="checkbox"/>	<input type="checkbox"/>	EHMT1	<input type="checkbox"/>	<input type="checkbox"/>	KATNAL2	<input type="checkbox"/>	<input type="checkbox"/>	NSUN2	<input type="checkbox"/>	<input type="checkbox"/>	SATB2	<input type="checkbox"/>	<input type="checkbox"/>	TCF4	<input type="checkbox"/>
<input type="checkbox"/>	CACNA1C	<input type="checkbox"/>	<input type="checkbox"/>	EPM2A	<input type="checkbox"/>	<input type="checkbox"/>	KCNA2	<input type="checkbox"/>	<input type="checkbox"/>	OCRL	<input type="checkbox"/>	<input type="checkbox"/>	SCARB2	<input type="checkbox"/>	<input type="checkbox"/>	TIMM8A	<input type="checkbox"/>
<input type="checkbox"/>	CASK	<input type="checkbox"/>	<input type="checkbox"/>	FGD1	<input type="checkbox"/>	<input type="checkbox"/>	KCNC1	<input type="checkbox"/>	<input type="checkbox"/>	OFD1	<input type="checkbox"/>	<input type="checkbox"/>	SCN1A	<input type="checkbox"/>	<input type="checkbox"/>	TPP1	<input type="checkbox"/>
<input type="checkbox"/>	CC2D1A	<input type="checkbox"/>	<input type="checkbox"/>	FLNA	<input type="checkbox"/>	<input type="checkbox"/>	KCNJ10	<input type="checkbox"/>	<input type="checkbox"/>	OPHN1	<input type="checkbox"/>	<input type="checkbox"/>	SCN1B	<input type="checkbox"/>	<input type="checkbox"/>	TRAPPC9	<input type="checkbox"/>
<input type="checkbox"/>	CDKL5	<input type="checkbox"/>	<input type="checkbox"/>	FMR1 *	<input type="checkbox"/>	<input type="checkbox"/>	KCNQ2	<input type="checkbox"/>	<input type="checkbox"/>	OTC	<input type="checkbox"/>	<input type="checkbox"/>	SCN2A	<input type="checkbox"/>	<input type="checkbox"/>	TSC1	<input type="checkbox"/>
<input type="checkbox"/>	CHD2	<input type="checkbox"/>	<input type="checkbox"/>	FOLR1	<input type="checkbox"/>	<input type="checkbox"/>	KCNQ3	<input type="checkbox"/>	<input type="checkbox"/>	PACS1	<input type="checkbox"/>	<input type="checkbox"/>	SCN8A	<input type="checkbox"/>	<input type="checkbox"/>	TSC2	<input type="checkbox"/>
<input type="checkbox"/>	CHD7	<input type="checkbox"/>	<input type="checkbox"/>	FOXG1	<input type="checkbox"/>	<input type="checkbox"/>	KCNT1	<input type="checkbox"/>	<input type="checkbox"/>	PAK3	<input type="checkbox"/>	<input type="checkbox"/>	SHANK3	<input type="checkbox"/>	<input type="checkbox"/>	TUSC3	<input type="checkbox"/>
<input type="checkbox"/>	CHD8	<input type="checkbox"/>	<input type="checkbox"/>	FOXP1	<input type="checkbox"/>	<input type="checkbox"/>	KCTD7	<input type="checkbox"/>	<input type="checkbox"/>	PCDH19	<input type="checkbox"/>	<input type="checkbox"/>	SIK1	<input type="checkbox"/>	<input type="checkbox"/>	UBE2A	<input type="checkbox"/>
<input type="checkbox"/>	CHRNA2	<input type="checkbox"/>	<input type="checkbox"/>	FOXP2	<input type="checkbox"/>	<input type="checkbox"/>	KDM5C	<input type="checkbox"/>	<input type="checkbox"/>	PDHA1	<input type="checkbox"/>	<input type="checkbox"/>	SLC13A5	<input type="checkbox"/>	<input type="checkbox"/>	UBE3A	<input type="checkbox"/>
<input type="checkbox"/>	CHRNA4	<input type="checkbox"/>	<input type="checkbox"/>	FTSJ1	<input type="checkbox"/>	<input type="checkbox"/>	KIAA2022	<input type="checkbox"/>	<input type="checkbox"/>	PHF6	<input type="checkbox"/>	<input type="checkbox"/>	SLC16A2	<input type="checkbox"/>	<input type="checkbox"/>	UPF3B	<input type="checkbox"/>
<input type="checkbox"/>	CHRN2	<input type="checkbox"/>	<input type="checkbox"/>	GABRA1	<input type="checkbox"/>	<input type="checkbox"/>	KIF1A	<input type="checkbox"/>	<input type="checkbox"/>	PHF8	<input type="checkbox"/>	<input type="checkbox"/>	SLC25A22	<input type="checkbox"/>	<input type="checkbox"/>	VPS13B	<input type="checkbox"/>
<input type="checkbox"/>	CLN3	<input type="checkbox"/>	<input type="checkbox"/>	GABRB3	<input type="checkbox"/>	<input type="checkbox"/>	L1CAM	<input type="checkbox"/>	<input type="checkbox"/>	PIGA	<input type="checkbox"/>	<input type="checkbox"/>	SLC2A1	<input type="checkbox"/>	<input type="checkbox"/>	WDR45	<input type="checkbox"/>
<input type="checkbox"/>	CLN5	<input type="checkbox"/>	<input type="checkbox"/>	GABRG2	<input type="checkbox"/>	<input type="checkbox"/>	LAMP2	<input type="checkbox"/>	<input type="checkbox"/>	PIGN	<input type="checkbox"/>	<input type="checkbox"/>	SLC35A2	<input type="checkbox"/>	<input type="checkbox"/>	ZC4H2	<input type="checkbox"/>
<input type="checkbox"/>	CLN6	<input type="checkbox"/>	<input type="checkbox"/>	GAMT	<input type="checkbox"/>	<input type="checkbox"/>	LG1	<input type="checkbox"/>	<input type="checkbox"/>	PLCB1	<input type="checkbox"/>	<input type="checkbox"/>	SLC6A1	<input type="checkbox"/>	<input type="checkbox"/>	ZEB2	<input type="checkbox"/>
<input type="checkbox"/>	CLN8	<input type="checkbox"/>	<input type="checkbox"/>	GATM	<input type="checkbox"/>	<input type="checkbox"/>	LINS	<input type="checkbox"/>	<input type="checkbox"/>	PLP1	<input type="checkbox"/>	<input type="checkbox"/>	SLC6A8	<input type="checkbox"/>			
<input type="checkbox"/>	CNTNAP2	<input type="checkbox"/>	<input type="checkbox"/>	GDI1	<input type="checkbox"/>	<input type="checkbox"/>	MAN1B1	<input type="checkbox"/>	<input type="checkbox"/>	PNKP	<input type="checkbox"/>	<input type="checkbox"/>	SLC9A6	<input type="checkbox"/>			

*FMR1 CGG repeat analysis as an additional test bill separately (test code 4544) **ADD**

Total Gene Count (REQUIRED: include total number of genes on your CustomNext-Neuro panel): _____

Notes: _____

ExomeNext Medical Necessity Form - Page 4 of 4

REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is ONLY required if you are requesting reflex to Exome sequencing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

- Yes, date performed: _____
 No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

- Multiple abnormalities affecting unrelated organ systems (please specify): _____
OR two of the following:
 Abnormality affecting a single organ system(specify): _____
 Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)
 Family history strongly implicating a genetic etiology (please specify findings and relationships)
 Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

- Yes (please describe): _____
 No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

- Chromosomal microarray
 Single gene test(s): _____
 Multigene panel(s): _____
 Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

- Imaging study: _____
 Surgery: _____
 Biopsy: _____
 Other: _____