

**COMPLETE ENTIRE FORM AND SUBMIT CLINIC NOTES/PEDIGREE 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)						
Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA, Source: <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured amniocytes <input type="checkbox"/> Other:						
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant			<input type="checkbox"/> Current diagnosis of heme malignancy, Type:			
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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.						
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.						
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 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: We will start testing immediately, unless you check the box below. We will attempt to contact you if your estimated out-of-pocket costs are > USD \$100. <input type="checkbox"/> Do not start testing until I approve payment terms regarding estimated out-of-pocket costs Patient agrees to contact regarding out-of-pocket amount by: <input type="checkbox"/> Email <input type="checkbox"/> Phone (includes texts) - confirm mobile # _____			Contact Name		E-mail/Fax	
Special Billing Notes:			<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)	
<p><b>Patient Acknowledgement:</b> 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><b>For patient payment by credit card:</b> I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for <b>Ambry's Patient Assistance Program</b>, 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. <b>NOTE:</b> If left blank, consent is interpreted as "NO".						
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:					Date:	

## Clinical Genomics Test Requisition Form - Page 2 of 5

**ONLY COMPLETE FOR EXOMENEXT-TRIO ORDERS OR IF FAMILY MEMBERS WILL BE SUBMITTED FOR CO-SEGREGATION.**  
 All family member specimens must be received within 4 weeks of order. Otherwise test will be run as proband only.

FAMILY MEMBER #1 INFORMATION			
Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
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:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State Zip
			Relationship to proband
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, Source:	<input type="checkbox"/> Other:		
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant	<input type="checkbox"/> Current diagnosis of heme malignancy, Type:		
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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.			
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.			
CLINICAL INFORMATION			
Is Family Member affected with the same phenotype as the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly			
Describe:			
SECONDARY FINDINGS			
Secondary findings results are available for each family member sequenced as part of the trio. Check below to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported. (For expanded secondary findings options and pricing please complete the "ExomeNext Expanded Secondary Findings Request Form").			
<input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.			

FAMILY MEMBER #2 INFORMATION			
Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email
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:		
Address: <input type="checkbox"/> Same as Proband	Address	City	State Zip
			Relationship to proband
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, Source:	<input type="checkbox"/> Other:		
<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant	<input type="checkbox"/> Current diagnosis of heme malignancy, Type:		
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 <a href="http://ambrygen.com/specimen-requirements">ambrygen.com/specimen-requirements</a> for details.			
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.			
CLINICAL INFORMATION			
Is Family Member affected with the same phenotype as the proband? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Possibly			
Describe:			
SECONDARY FINDINGS			
Secondary findings results are available for each family member sequenced as part of the trio. Check below to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported. (For expanded secondary findings options and pricing please complete the "ExomeNext Expanded Secondary Findings Request Form").			
<input type="checkbox"/> Opt-out: I choose to decline the ACMG Recommended List of secondary findings.			

## Clinical Genomics Test Requisition Form - Page 3 of 5

### INDICATION(S) FOR TESTING

ICD-10 code(s): \_\_\_\_\_ Will patient management be changed depending on the test results?  Yes  No

### PROBAND'S PRIMARY INDICATION FOR TESTING

Please describe in a few words the main reason for ordering exome testing (Please also provide clinic notes and pedigree):  
 \_\_\_\_\_  
 \_\_\_\_\_

### PROBAND'S CLINICAL OVERVIEW (Check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Audiologic/Otolaryngologic<br><input type="checkbox"/> Cardiovascular<br><input type="checkbox"/> Craniofacial<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Dysmorphic Features<br><input type="checkbox"/> Dermatologic<br><input type="checkbox"/> Endocrine<br><input type="checkbox"/> Fetal (Please complete and attach "ExomeNext Prenatal Form")<br><input type="checkbox"/> Gastrointestinal<br><input type="checkbox"/> Genitourinary<br><input type="checkbox"/> Growth Disorders:<br><input type="checkbox"/> Undergrowth<br><input type="checkbox"/> Overgrowth<br><input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Hematologic<br><input type="checkbox"/> Immunologic/Infectious/Allergy<br><input type="checkbox"/> Metabolic/Biochemical<br><input type="checkbox"/> Movement Disorder<br><input type="checkbox"/> Musculoskeletal/Structural<br><input type="checkbox"/> Multiple Congenital Anomalies<br><input type="checkbox"/> Neurologic<br><input type="checkbox"/> Seizures/Epilepsy<br><input type="checkbox"/> Autism Spectrum Disorder<br><input type="checkbox"/> Developmental Delay/Intellectual disability<br><input type="checkbox"/> Ataxia/Spasticity<br><input type="checkbox"/> Psychiatric<br><input type="checkbox"/> Abnormal brain MRI<br><input type="checkbox"/> Obstetric<br><input type="checkbox"/> Oncologic | <input type="checkbox"/> Ophthalmologic<br><input type="checkbox"/> Pulmonary<br><input type="checkbox"/> Renal<br><input type="checkbox"/> Tone abnormalities<br><input type="checkbox"/> Hypotonia<br><input type="checkbox"/> Hypertonia |
|--|---|---|

### ADDITIONAL CLINICAL DETAILS

Autism:  no autistic behaviors  autistic behaviors (describe): \_\_\_\_\_

Dysmorphic Features (describe): \_\_\_\_\_

Congenital Anomalies (describe): \_\_\_\_\_

History of Seizures  Yes  No  diagnosed epilepsy Seizure type(s): \_\_\_\_\_

Progressive disease  Yes  No

**Previous Studies**

MRI/CT studies (findings): \_\_\_\_\_

Chromosome analysis: \_\_\_\_\_ Microarray analysis: \_\_\_\_\_

Other molecular studies: \_\_\_\_\_

Growth Indices (current): Head circumference: \_\_\_\_\_% Weight: \_\_\_\_\_% Height: \_\_\_\_\_%

Differential diagnosis/Genes of interest: \_\_\_\_\_

### FAMILY HISTORY (Please attach pedigree)

Is anyone in the family affected with a similar phenotype as the proband?  NO  YES, please list exact relationship to proband, symptoms and age of onset of symptoms:  
 \_\_\_\_\_

Is there any consanguinity (conception between blood relatives) in the family?  NO  YES If yes please describe: \_\_\_\_\_

## Clinical Genomics Test Requisition Form - Page 4 of 5

Please check the box next to the test(s) being ordered below. 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
<b>Karyotype</b>			
<input type="checkbox"/>	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)
<input type="checkbox"/>	Karyotype, rule out mosaic	3662	Chromosome analysis (requires green-top sodium-heparin tube)
<b>Chromosomal Microarray Analysis</b>			
<input type="checkbox"/>	SNP Array <sup>^</sup>	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
<input type="checkbox"/>	Familial targeted microarray <sup>^</sup>	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: _____
<b>Exome Sequencing</b>			
<input type="checkbox"/>	ExomeNext- <i>Proband</i>	9993	Proband only exome sequencing Secondary Findings*: <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext- <i>Proband</i> plus mtDNA	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings*: <input type="checkbox"/> Opt-out
If only one family member is available, please order proband testing (9993 or 9994) and the family member can undergo co-segregation analysis ("family studies")			
<input type="checkbox"/>	ExomeNext- <i>Trio</i>	9995	Trio exome sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings*: <input type="checkbox"/> Opt-out
<input type="checkbox"/>	ExomeNext- <i>Trio</i> 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"/>	ExomeNext- <i>Rapid</i> **	9999R	Rapid Trio exome sequencing plus mtDNA sequencing Candidate (Novel) Genetic Etiologies: <input type="checkbox"/> Opt-out Secondary Findings*: <input type="checkbox"/> Opt-out
Order through AP***	ExomeNext- <i>Select</i>	9500	Up to 500 gene custom exome sequencing test

<sup>^</sup>Buccal swab accepted for SNP Array  
<sup>\*</sup>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.  
<sup>\*\*</sup>Institutional billing or patient payment only  
<sup>\*\*\*</sup>AP is AmbryPort, our online portal [ambrygen.com/ap](http://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:  will be provided  already at Ambry  not available

**FOR PRENATAL SPECIMENS ONLY: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)**

1260 MCC for amniotic fluid culture or CVS (run concurrently with test)  
 1262 MCC Reference for maternal blood sample (No Charge)

**OTHER ORDER**

Please visit [ambrygen.com/tests](http://ambrygen.com/tests) for details.  
 Test Code: \_\_\_\_\_ Test Name: \_\_\_\_\_

Notes:

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**ORDERING CHECKLIST (Required\*)**

Proband specimen  
 Clinical Genomics TRF with patient & clinician signatures  
 Clinical history (attach clinic notes)  
 Medical Necessity Form (insurance orders only) (see page 5)  
 Copy of Insurance Card (insurance orders only)  
*\*Orders with missing requirements will be placed on hold until all requirements are received.*

**ORDERING CHECKLIST (Highly Recommended)**

Family member specimens\*\*  
 Family history or pedigree  
 Previous test results  
*\*\*Please send all first degree and other informative relatives within 4 weeks of the order.*

**CONTACT INFORMATION**

For ExomeNext preverification requests please send the Medical Necessity Form and Clinical Genomics TRF to [preverification@ambrygen.com](mailto:preverification@ambrygen.com) or fax to 949-900-5501. All other documents can be secure uploaded at [ambrygen.com/secure-upload](http://ambrygen.com/secure-upload), or faxed to 949-900-5501.

AmbryPort is a new secure client portal that allows order submission, test status updates, insurance authorization status and report downloads. All required documents can be completed and directly uploaded through AmbryPort during the ordering process or after order submission. Please visit [portal.ambrygen.com/signup](http://portal.ambrygen.com/signup) to sign up.

## ExomeNext Medical Necessity Form - Page 5 of 5

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

This form is required if you are ordering Exome testing 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: \_\_\_\_\_