

**COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS**

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**PLEASE SUBMIT THE FOLLOWING WITH THE TRF:**  
1. Clinic Notes 2. Pedigree 3. Insurance Card

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:									
FAMILY HISTORY* <input type="checkbox"/> None (maternal) <input type="checkbox"/> None (paternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> Paternal hx unknown															
<i>*Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigrees and other clinical family history notes should be supplied as well when sending in your order.</i>															
Relation to patient		Mat	Pat	H/o cardio disease		Dx age		Relation to patient		Mat	Pat	H/o cardio disease		Dx age	
		<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>				
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 #								
<input type="checkbox"/> Specimen is post-mortem Date of death: _____ Specimen Type: _____															
<i>*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. **If submitting Cord Blood or a fetal specimen, please see bottom of page 3 for Maternal Cell Contamination sample submission test codes.</i>															
Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send kit to patient* <i>*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.</i>															
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 <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.															
<b>Signature Required for Processing Medical Professional Signature:</b>								<b>Date:</b>							
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		Phone Number		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>															
<b>FOR NY RESIDENTS:</b> <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".															
<b>Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:</b>								<b>Date:</b>							

## Cardiovascular Test Requisition Form - Page 2 of 2

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)			
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Family history <input type="checkbox"/> Positive or normal control <input type="checkbox"/> Other _____			ICD-10 code(s): _____
Will patient management be changed depending on the test results? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> STAT TEST: Date results needed (if known): _____			
CLINICAL HISTORY (PLEASE SUPPLY CLINIC NOTES AND PEDIGREE)			
<input type="checkbox"/> No personal history of cardiovascular disease Sudden cardiac arrest <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ Syncope <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ History of cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ Type(s) of cardiomyopathy: _____ History of Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____		Type(s) of Arrhythmia: _____ <input type="checkbox"/> Clinical diagnosis of Marfan Syndrome or other connective tissue disorder <input type="checkbox"/> Aortic Aneurysm/Dilation Age at dx: _____ <input type="checkbox"/> Other Aneurysm Location: _____ Age at dx: _____ <input type="checkbox"/> Aortic/Vascular Dissection Location: _____ Age at dx: _____ <input type="checkbox"/> History of familial hypercholesterolemia <input type="checkbox"/> Other cardiac history: _____	
CLINICAL TESTING AND PROCEDURES			
LDL-C: _____ Total Cholesterol: _____ Age at Testing: _____ Procedures (e.g.: EKG, ECHO, etc.) Age: _____ Result (e.g.: LVIDd, PWd, Qtc, etc.): _____ Type: _____ Cardiovascular Device implant (eg: Pacemaker, ICD, LVAD, etc.): Age at implantation: _____ Type: _____			
PREVIOUS GENETIC TESTING (PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS) <input type="checkbox"/> No previous molecular and/or genetic testing			
Test	Laboratory	Results	
CARDIOVASCULAR TEST OPTIONS			
Check to order	Test Name	Test Code	Description
Cardiomyopathy Panels			
<input type="checkbox"/>	HCMFirst	8935	First tier test of 2 most common genes for hypertrophic cardiomyopathy ( <i>MYBPC3</i> , <i>MYH7</i> )
<input type="checkbox"/>	HCMNext	8936	27 genes for hypertrophic cardiomyopathy
<input type="checkbox"/>	HCMNext Reflex	8883	HCMFirst reflex to HCMNext
<input type="checkbox"/>	DCMNext	8884	36 genes for dilated cardiomyopathy
<input type="checkbox"/>	CMNext	8887	55 genes for hereditary 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
Arrhythmia, Long QT, and Brugada Panels			
<input type="checkbox"/>	RhythmFirst	8888	12 genes for long QT, Brugada, and short QT syndromes
<input type="checkbox"/>	RhythmNext	8900	36 genes for long QT syndrome, Brugada syndrome, and other inherited arrhythmias
<input type="checkbox"/>	RhythmNext Reflex	8901	RhythmFirst with reflex to RhythmNext
<input type="checkbox"/>	CPVTNext	8902	6 genes for catecholaminergic polymorphic ventricular tachycardia
Aneurysms and Related Disorders			
<input type="checkbox"/>	TAADNext	8789	22 genes for thoracic aortic aneurysms/dissections
<input type="checkbox"/>	Marfan syndrome	8781	<i>FBN1</i>
<input type="checkbox"/>	Marfan reflex to TAADNext	8783	<i>FBN1</i> reflex to TAADNext
<input type="checkbox"/>	Ehlers-Danlos vascular type (EDS IV)	8790	<i>COL3A1</i>
<input type="checkbox"/>	Ehlers-Danlos reflex to TAADNext	8791	<i>COL3A1</i> reflex to TAADNext
Check to order	Test Name	Test Code	Description
Comprehensive Cardiovascular Panels			
<input type="checkbox"/>	CardioNext	8911	85 genes for hereditary cardiomyopathies and arrhythmias
<input type="checkbox"/>	CustomNext-Cardio	9520	Up to 106 gene custom hereditary cardiomyopathies and arrhythmias test. Required: completed CustomNext-Cardio supplemental form. <a href="http://ambrygen.com/forms">ambrygen.com/forms</a>
Familial Hypercholesterolemia			
<input type="checkbox"/>	FHNext	8680	4 genes ( <i>APOB</i> , <i>LDLR</i> , <i>LDLRAP1</i> , <i>PCSK9</i> )
<input type="checkbox"/> Check this box if you would like to have the <i>SLC01B1</i> c.521T>C polymorphism reported, which has been associated in medical literature with statin-induced myopathies			
Hereditary Hemorrhagic Telangiectasia (HHT)			
<input type="checkbox"/>	HHTNext	8672	5 genes for HHT
Noonan and Related Syndromes			
<input type="checkbox"/>	Noonan syndrome	8402	<i>PTPN11</i> , <i>SOS1</i> , <i>KRAS</i> , <i>RAF1</i>
Clinical Genomics and Other Cardiovascular Genetic Tests			
<input type="checkbox"/>	Transthyretin amyloidosis	1560	<i>TTR</i>
<input type="checkbox"/>	SNP Array*	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)
OTHER ORDER			
Test Code: _____ Test Name: _____			
SPECIFIC 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)			