

**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 <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><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.</i></p> <p><i>**If submitting Cord Blood or a fetal specimen, please see bottom of page 2 for Maternal Cell Contamination sample submission test codes.</i></p>						
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 <input type="checkbox"/> STAT TEST: Date results needed (if known): _____						
PATIENT HISTORY <input type="checkbox"/> No personal history of pulmonology disease						
PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date:			Upcoming procedure date:			
<b>Reasons for Testing</b>						
<input type="checkbox"/> Positive newborn screen <input type="checkbox"/> Infections: _____ <input type="checkbox"/> Sweat chloride: _____mmol/L <input type="checkbox"/> Sweat chloride: <input type="checkbox"/> <40 <input type="checkbox"/> 40-60 <input type="checkbox"/> >60 <input type="checkbox"/> CBAVD <input type="checkbox"/> Meconium ileus <input type="checkbox"/> Pancreatic insufficiency IRT level: _____ <input type="checkbox"/> Respiratory distress, explain: _____ <input type="checkbox"/> Respiratory assistance devices: _____ <input type="checkbox"/> Ultrasound findings: _____ <input type="checkbox"/> Other: _____			<b>Relevant lab results (include copies if possible)</b>  <div style="background-color: #0070C0; color: white; padding: 2px;"><b>FAMILY HISTORY</b></div> <input type="checkbox"/> None (maternal) <input type="checkbox"/> Maternal hx unknown <input type="checkbox"/> None (paternal) <input type="checkbox"/> Paternal hx unknown Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Diagnosis _____ Dx age _____ Relationship to patient _____ <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal Diagnosis _____ Dx age _____			
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 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. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity (unless this box is checked <input type="checkbox"/> ).						
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			
Special Billing Notes:			Phone Number		E-mail/Fax	
			<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambray Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)	
<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 Ambray Genetics Corporation (Ambray), authorize Ambray 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 Ambray money received from my health insurance company. <b>For patient payment by credit card:</b> I hereby authorize Ambray Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambray'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 Ambray Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.						
<b>FOR NY RESIDENTS:</b> <input type="checkbox"/> I am a New York resident and I give Ambray 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:		

**PLEASE SUBMIT THE FOLLOWING WITH THE TRF:**

1. Clinic Notes    2. Pedigree    3. Insurance Card

## Pulmonology Test Requisition Form - Page 2 of 2

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>Congenital Central Hypoventilation Syndrome</b>			
<input type="checkbox"/>	Congenital central hypoventilation syndrome	1580	<i>PHOX2B</i> gene sequence
<b>Cystic Fibrosis</b>			
<input type="checkbox"/>	508 FIRST	1002	<input type="checkbox"/> Report poly T/TG status Test for <i>CFTR</i> deltaF508 mutation with reflex to <i>CFTR</i> gene sequence and deletion/duplication
<input type="checkbox"/>	<i>CFTR</i> gene sequence and deletion/duplication analysis	1007	<input type="checkbox"/> Report poly T/TG status
<b>SPECIFIC SITE ANALYSIS (Please include a copy of relative's report)</b>			
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			
<b>FOR PRENATAL SPECIMENS OR CORD BLOOD: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)</b>			
<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)	

Check to order	Test Name	Test Code	Description
<b>Primary Ciliary Dyskinesia</b>			
<input type="checkbox"/>	PCDNext	8122	<input type="checkbox"/> Report poly T/TG status 21 genes for primary ciliary dyskinesia
<b>Pulmonary Fibrosis</b>			
<input type="checkbox"/>	Telomere-related pulmonary fibrosis	8140	<i>TERT, TERC</i>
<b>Respiratory Distress Syndrome</b>			
<input type="checkbox"/>	Surfactant dysfunction panel	8100	<i>ABCA3, SFTPB, SFTPC</i> gene sequence
<b>Clinical Genomics</b>			
<input type="checkbox"/>	Karyotype	3660	Chromosome analysis (requires green-top sodium-heparin tube)
<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: _____
<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
<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)