hATTR Compass
Map Your Genetic Journey

Ambry Genetics
A Konica Minolta Company

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Test Requisition Form

PATIENT INFORMATION (Patient must be 18 years or older)

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Phone Number	Email

Address City State Zip	Biological Sex	Ethnicity
	☐ F ☐ M	☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Other:

SPECIMEN INFORMATION*

Type(s) ☐ Blood ☐ Saliva ☐ Send saliva kit to patient** ☐ Phlebotomy request^ ☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

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 ambrygen.com/specimen-requirements for details.
**By checking this box and submitting the completed form, a saliva kit will be sent to the patient's address above. Your patient will be able to submit a saliva sample directly to Ambry for testing.
^ Available for US patients only. 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

PATIENT ELIGIBILITY: PLEASE READ CAREFULLY

Patients must be 18 years and older and have a family history of hATTR amyloidosis OR have at least 2 of the following clinical symptoms/manifestations related to hATTR amyloidosis.

Does the patient have a family history of hATTR amyloidosis? ☐ Yes ☐ No ☐ Patient does not know

SYMPTOM CHECKLIST (Please check if the patient has previously had or currently has any of the following clinical manifestations and indicate symptom onset age.)

☐ Sensory dysfunction (e.g. numbness and tingling in feet and/or hands, sensitivity to pain and temperature, pain in extremities); **Symptom onset age:**_____
☐ Motor dysfunction (e.g. muscle weakness, impaired balance, difficulty walking); **Symptom onset age:**_____
☐ Autonomic dysfunction (e.g., orthostatic hypotension, early satiety, nausea and vomiting, changes in GI motility, erectile dysfunction, bladder dysfunction); **Symptom onset age:**_____
☐ Gastrointestinal (diarrhea or constipation not responding to typical therapy, or alternating bouts of diarrhea/constipation); **Symptom onset age:**_____
☐ Heart disease (e.g., shortness of breath, edema, fatigue, palpitations, and arrhythmias); **Symptom onset age:**_____
☐ Renal issues (proteinuria or renal insufficiency/failure); **Symptom onset age:**_____
☐ Bilateral Carpal tunnel syndrome; **Symptom onset age:**_____
☐ Lumbar spinal stenosis; **Symptom onset age:**_____
☐ Unintentional weight loss; **Symptom onset age:**_____
☐ Myocardial radiotracer (^{99m}Tc-PYP/DPD/HMDP) uptake on bone scintigraphy and the absence of a monoclonal protein in serum or urine; **Symptom onset age:**_____
☐ Histological confirmation and typing of TTR amyloid; **Symptom onset age:**_____
☐ Other_____
Approximately, how many doctors has the patient seen about this condition? _____

CHECK TO ORDER	TEST NAME	TEST CODE	# OF GENES	GENE LIST
Please select only one test.				
☐	Transthyretin amyloidosis	1560	1	*TTR*
☐	CardioNext (includes *TTR*)	8911	92	***TTR***, *ABCC9, ACTC1, ACTN2, ALMS1, ALPK3, AKAP9, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FLNC, FKTN, FXN, GATA4, GATAD1, GLA, GPD1L, HCN4, JAG1, JPH2, JUP, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, LAMA4, LAMP2, LDB3, LMNA, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYOZ2, MYPN, NEXN, NKX2-5, PKP2, PLN, PRKAG2, PTPN11, RAF1, RBM20, RIT1, RYR2, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SCN10A, SNTA1, SOS1, TAZ, TBX1, TBX20, TBX5, TCAP, TECRL, TGFB3, TMEM43, TMPO, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTN, TXNRD2, VCL*
☐	NeuropathySelect (includes *TTR*)	9570	80	***TTR***, *AARS, AIFM1, APOA1, ATL1, ATL3, ATP7A, BICD2, BSCL2, CHCHD10, DCTN1, DNAJB2, DNM2, DNMT1, DST, DYNC1H, EGR2, FAM134B , FBXO38, FGD4, FIG4, FUS, GAN, GARS, GDAP1, GJB1, GNB4, GSN, HARS, HINT1, HSPB1, HSPB8, IGHMBP2, IKBKAP , INF2, KIF1A, LITAF, LMNA, LRSAM1, MARS, MFN2, MORC2, MPZ, MTMR2, NDRG1, NEFH, NEFL, NGF, NTRK1, OPTN, PDK3, PLEKHG5, PMP22, PRDM12, PRPS1, PRX, RAB7A, REEP1, SBF2, SCN11A, SCN9A, SETX, SH3TC2, SIGMAR1, SLC25A46, SLC52A2, SLC52A3, SLC5A7, SPG11, SPTLC1, SPTLC2, TARDBP, TFG, TRPV4, UBA1, VAPB, VRK1, WNK1, YARS, VCP*

Genetic Counseling: Ambry and Akcea have partnered with PWNHealth to offer no cost, pre- and/or post-test genetic counseling for your patients. Genetic counseling is not required for testing. By checking the boxes below, I agree to allow Ambry to facilitate the provision of pre-test and/or post-test genetic counseling services by PWNHealth.
☐ Yes. I request a pre-test genetic counseling session for my patient. ☐ Yes. I request a post-test genetic counseling session for my patient.

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 testing is medically necessary and test results may impact medical management for the patient. Furthermore, all information on this ordering form is true to the best of my knowledge. I understand that organization and clinician contact information provided may be shared with third parties including Akcea Therapeutics and Backpack Health and may contact you in connection with the Genetic Pathway Program. My patient would like to receive more information from Backpack Health and consents to share patient's name and email with this third party (unless this box is checked ☐).

Signature Required for Processing Medical Professional Signature: Date:

To request a complimentary specimen collection kit visit: ambrygen.com/clinician/order-sample-kit