

## GENERAL TEST REQUISITION

Arrows "▶" Mandatory for Processing

### Patient Information

<b>▶ DOB</b> MM - DD - YEAR	<b>▶ Last Name</b>	<b>▶ First Name</b>	M Initial
<b>▶ Gender</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>▶ Street Address, City, State, Zip</b>		
<b>▶ Ethnicity</b> <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"/> Specify: _____	<b>▶ Home Phone</b> Work/Cell		

<b>Specimen</b> <b>▶ Collection Date:</b> _____ Specimen ID: _____ MR#: _____ Specimen Type (See Requirements) <input type="checkbox"/> Blood <input type="checkbox"/> Blood Spot <input type="checkbox"/> DNA <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> Cultured CVS <input type="checkbox"/> CVS Tissue <input type="checkbox"/> Other: _____	<b>Previous Test History</b> Previously Detected Mutations: _____ Testing Lab: _____ Patient previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Relation: _____ Name: _____ Relation: _____ Name: _____ Relation: _____ Name: _____ Relation: _____
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Contact and Organization Information	
▶ Authorized Ordering Physician	NPI#
▶ Ph	▶ FX
▶ Facility Name and Address	ID#

Additional Results Recipient
Medical Professional Name:
Facility Name and Address <span style="float: right;"><input type="checkbox"/> Same As Above</span>
Ph <span style="float: right;">Fx</span>

<b>▶ Form Completed by</b>	<b>▶ Phone</b>
By ordering testing, the medical professional or authorized person acknowledges the patient has been supplied information regarding genetic Testing and the patient has given consent for genetic testing to be performed.	
Does this patient give consent to the use of their sample for research? <input type="checkbox"/> Yes <input type="checkbox"/> No Consent is implied if a box is not marked	
<b>Medical Professional Signature</b> Mandatory for New York State X _____ Date	

<b>▶ Indication for Testing</b> <i>(please list clinical findings)</i> <input type="checkbox"/> Diagnostic <input type="checkbox"/> Carrier Screening <input type="checkbox"/> Research <input type="checkbox"/> Positive Newborn Screen <input type="checkbox"/> Family History <input type="checkbox"/> Other _____ <b>ICD-9 Codes:</b> _____	<b>List Clinical Findings:</b>  <b>Sweat Chloride:</b>
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### Billing Information - Mandatory For Processing

AMBRY GENETICS provides a selection of convenient billing options. Please choose an option below and supply all requested information for your billing option. Keep in mind that patient testing will be delayed until all of the billing requirements have been met. Choose an option below.

<input type="checkbox"/> <b>Bill Facility</b> <input type="checkbox"/> same as ordering facility	<input type="checkbox"/> <b>Bill Insurance</b> Include card copy (both sides)	<input type="checkbox"/> <b>Pre-Payment</b>
Facility Name	Name of Insured	Payment Type <input type="checkbox"/> Check <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> Visa <input type="checkbox"/> American Express
Address, City, State, Zip	Insurance Company Name and Address	Card Number <span style="float: right;">Exp Date</span>
		Cardholder Name <span style="float: right;">Amount \$</span>
Contact Person	Insurance Phone	Signature X <span style="float: right;">Date</span>
Contact Person Phone	Member ID #	<b>Patient Acknowledgement</b> I hereby authorize my insurance benefits to be paid directly to Ambry Genetics Corporation and authorize them to release medical information concerning my testing to my insurer. I hereby acknowledge I am financially responsible for any amounts not paid by insurer.
	Group #	
	Authorization #	Date X <span style="float: right;">Date</span>

**MARK A TEST ON SUBSEQUENT PAGES FOR PROCESSING**

Thank You for Choosing Ambry Genetics

► Test Directory

Gene Sequence Analysis (unless otherwise indicated)

CANCER	DIAMOND-BLACKFAN ANEMIA (DBA)
<input type="checkbox"/> 3040 Ambry Test: APC Amplified (APC sequence and deletion/duplication) <input type="checkbox"/> 8500 Ambry SEQUENCE™: HNPCC/Lynch Syndrome (Complete pathway, steps 1 and 2) <input type="checkbox"/> 8504 Step 1 only (MLH1 & MSH2 sequence) <input type="checkbox"/> 8506 Step 2 only (MLH1/MSH2/MSH6 deletion/duplication, MSH6 sequence) <input type="checkbox"/> 8508 HNPCC/Lynch Syndrome, MLH1-Related (seq. and deletion/duplication) <input type="checkbox"/> 8510 HNPCC/Lynch Syndrome, MSH2-Related (seq. and del.dup, incl. TACSTD1/EpCAM) <input type="checkbox"/> 8512 HNPCC/Lynch Syndrome, MSH6-Related (sequence and deletion/duplication) <input type="checkbox"/> 2240 HNPCC/Lynch Syndrome, TACSTD1/EpCAM related (del/dup) <input type="checkbox"/> 8602 Juvenile Polyposis AMPLIFIED (BMPR1A, SMAD4, Del/Dup) <input type="checkbox"/> 8600 Juvenile Polyposis Deletion/Duplication (BMPR1A, SMAD4) <input type="checkbox"/> 2820 BMPR1A Gene Sequence Analysis <input type="checkbox"/> 1685 SMAD4 Gene Sequence Analysis <input type="checkbox"/> 2860 Li-Fraumeni Syndrome (TP53, P53) <input type="checkbox"/> 2640 Multiple Endocrine Neoplasia Type 1 (MEN1) <input type="checkbox"/> 2680 Ambry SEQUENCE™: Multiple Endocrine Neoplasia Type 2 (RET) <input type="checkbox"/> 2684 Step 1 only: exons 10,11,13-16 <input type="checkbox"/> 2360 PALB2-Related Pancreatic Cancer <input type="checkbox"/> 2100 PTEN-Related Disorders <input type="checkbox"/> 2766 Peutz-Jeghers AMPLIFIED (STK11) <input type="checkbox"/> 2600 Von Hippel-Lindau Disease (VHL)	<input type="checkbox"/> 8540 Ambry SEQUENCE™: DBA (All Genes, steps 1-3) <input type="checkbox"/> 2560 RPS19-Related DBA — Step 1 <input type="checkbox"/> 2460 RPL5-Related DBA — <input type="checkbox"/> 2480 RPL11-Related DBA — Step 2 <input type="checkbox"/> 2500 RPL35A-Related DBA — <input type="checkbox"/> 2588 RPS26-Related DBA — <input type="checkbox"/> 2584 RPS10-Related DBA — <input type="checkbox"/> 2580 RPS24-Related DBA — Step 3 <input type="checkbox"/> 2540 RPS17-Related DBA — <input type="checkbox"/> 2520 RPS7-Related DBA —
	DYSKERATOSIS CONGENITA (DC)
	<input type="checkbox"/> 8160 Ambry SEQUENCE™: DC (All Genes, steps 1-3) <input type="checkbox"/> 8162 DKC1- Related DC — <input type="checkbox"/> 8164 TINF2- Related DC — Step 1 <input type="checkbox"/> 2120 TERC- Related DC — <input type="checkbox"/> 2060 NHP2- Related DC — Step 2 <input type="checkbox"/> 2080 NOP10- Related DC — <input type="checkbox"/> 2140 TERT- Related DC — Step 3
CHROMOSOMAL MICROARRAY ANALYSIS (aCGH)	FAMILIAL HYPERCHOLESTEROLEMIA
<input type="checkbox"/> 3000 Ambry CMA: 180K Optimized Oligo Array	<input type="checkbox"/> 8580 Familial Hypercholesterolemia Panel (LDLR, partial APOB) <input type="checkbox"/> 8582 Familial Hypercholesterolemia AMPLIFIED™ (LDLR, partial APOB, reflex to LDLR del/dup) <input type="checkbox"/> 2780 LDLR Gene Sequence Analysis <input type="checkbox"/> 2784 LDLR Deletion/Duplication Analysis <input type="checkbox"/> 2800 APOB Partial Gene Analysis
CHROMOSOME STUDIES	GASTROENTEROLOGY
<input type="checkbox"/> 3660 High Resolution Chromosomes <input type="checkbox"/> 3662 High Resolution Chromosomes, Rule Out Mosaic <input type="checkbox"/> 3664 Routine Blood Chromosomes <input type="checkbox"/> 3666 Routine Blood Chromosomes, Rule Out Mosaic <input type="checkbox"/> 3668 Solid Tissue Chromosomes	<input type="checkbox"/> 8022 Pancreatitis Panel Plus (CFTR, PRSS1, SPINK1, CTRC) <input type="checkbox"/> 8020 Pancreatitis Panel (CFTR, PRSS1, SPINK1) <input type="checkbox"/> 8040 Pancreatitis Amplified Panel (CFTR, PRSS1, SPINK1, CFTR del/dup) <input type="checkbox"/> 1100 PRSS1 <input type="checkbox"/> 1120 SPINK1 <input type="checkbox"/> 1660 CTRC—Chymotrypsin C-Related Pancreatitis <input type="checkbox"/> 1840 Wilson Disease (ATP7B) <input type="checkbox"/> 1440 Shwachman-Diamond Syndrome (SBDS)
CONGENITAL HYPERINSULINISM (CH)	GENETICS
<input type="checkbox"/> 1340 GCK <input type="checkbox"/> 1370 GLUD1 (Hyperinsulinism-Hyperammonemia) <input type="checkbox"/> 1364 KCNJ11	<input type="checkbox"/> 1640 Alagille AMPLIFIED™ (JAG1) <input type="checkbox"/> 1641 Alagille Deletion/Duplication (JAG1) <input type="checkbox"/> 8620 Ambry SEQUENCE™: ALS (SOD1, reflex to ANG, FIG4, FUS, TARDBP) <input type="checkbox"/> 8622 ALS (SOD1 only) <input type="checkbox"/> 1320 Aminoglycoside-Related Hearing Loss (MT-RNR1) <input type="checkbox"/> 8520 Ambry SEQUENCE™: Angelman Syndrome (SNRPN, UBE3A) <input type="checkbox"/> 2420 Angelman-like Syndrome (SLC9A6) <input type="checkbox"/> 1800 Ashkenazi Jewish FlexPanel™ with all 11 conditions <input type="checkbox"/> 1804 Ashkenazi Jewish FlexPanel™ as marked below <input type="checkbox"/> Bloom <input type="checkbox"/> GSD1a <input type="checkbox"/> Canavan <input type="checkbox"/> MSUD <input type="checkbox"/> CF <input type="checkbox"/> MLIV <input type="checkbox"/> Fam. Dysaut. <input type="checkbox"/> Niemann-Pick A <input type="checkbox"/> Fanconi An.-C <input type="checkbox"/> Tay-Sachs <input type="checkbox"/> Gaucher <input type="checkbox"/> 1040 Beta Thalassemia Plus (HBB) <input type="checkbox"/> 1220 Canavan AMPLIFIED™ (ASPA) <input type="checkbox"/> 2380 CHARGE Syndrome (CHD7) <input type="checkbox"/> 1720 Fabry Disease (GLA) <input type="checkbox"/> 1820 Gaucher Disease (GBA) <input type="checkbox"/> 1600 Glutaric Acidemia Type 1 (GCDH) <input type="checkbox"/> 1880 Glycogen Storage Disease Type Ia (G6PC) <input type="checkbox"/> 1900 Glycogen Storage Disease Type Ib (SLC37A4) <input type="checkbox"/> 2746 HAE AMPLIFIED™ (SERPING1) <input type="checkbox"/> 2740 HAE SERPING1 Gene Sequence Analysis <input type="checkbox"/> 2744 HAE SERPING1 Deletion/Duplication Analysis <input type="checkbox"/> 2700 RET-Related Hirschsprung Disease <input type="checkbox"/> 2704 Step 1: exons 2,3,5,6,9,10,12,13,17 <input type="checkbox"/> 2706 Step 2: rest of gene
CYSTIC FIBROSIS (CFTR) & PULMONOLOGY	
<input type="checkbox"/> 1002 508 FIRST™ (deltaF508 screen, reflex to CF AMPLIFIED™) <input type="checkbox"/> 1012 508 ONLY™ (deltaF508 mutation only) <input type="checkbox"/> 1006 CF AMPLIFIED™ <input type="checkbox"/> Report PolyT / TG Repeat Status <input type="checkbox"/> 1000 CF Gene Sequence Analysis <input type="checkbox"/> 1004 CF Deletion/Duplication <input type="checkbox"/> 1010 CF TG Repeat Analysis (Poly T Variant & TG Repeat) <input type="checkbox"/> 1300 ABCA3 <input type="checkbox"/> 1140 Alpha-1 Antitrypsin Deficiency (SERPINA1) <input type="checkbox"/> 1580 Congenital Central Hypoventilation Syndrome (PHOX2B) <input type="checkbox"/> 8140 IPF Telomerase (TERT, TERC) <input type="checkbox"/> 8120 PCD 61 (DNAH5 & DNAI1 Mutation Panel) <input type="checkbox"/> 1540 Pulmonary Arterial Hypertension (PAH AMPLIFIED™ – BMPR2) <input type="checkbox"/> 1541 PAH Deletion/Duplication (BMPR2) <input type="checkbox"/> 1160 Surfactant Protein B (SFTPB) <input type="checkbox"/> 1180 Surfactant Protein C (SFTPC)	
DIABETES	
<b>Neonatal Diabetes</b> <input type="checkbox"/> 1360 KCNJ11 <input type="checkbox"/> 1620 INS <input type="checkbox"/> 1340 GCK (Neonatal)	

<b>► Test Directory</b>	<b>Gene Sequence Analysis (unless otherwise indicated)</b>
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<p><b>GENETICS, continued</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1940 Hunter Syndrome (<i>IDS</i>)</li> <li><input type="checkbox"/> 2160 Hurler Syndrome (<i>IDUA</i>)</li> <li><input type="checkbox"/> 2040 Infantile Spasms (<i>CDKL5</i>)</li> <li><input type="checkbox"/> 1860 Niemann-Pick Disease Types A &amp; B (<i>SMPD1</i>)</li> <li><input type="checkbox"/> 1760 PKU (<i>PAH</i> gene for Phenylketonuria)</li> <li><input type="checkbox"/> 1740 Pompe Disease (<i>GAA</i>)</li> <li><input type="checkbox"/> 2440 Prader-Willi/Angelman Syndrome (<i>SNRPN</i>)</li> <li><input type="checkbox"/> 2180 Smith-Lemli-Opitz Syndrome (<i>DHCR7</i>)</li> <li><input type="checkbox"/> 1240 Tay-Sachs Plus (<i>HEXA</i>)</li> <li><input type="checkbox"/> 1560 Transthyretin Amyloidosis (<i>TTR</i>)</li> <li><input type="checkbox"/> 1700 Warfarin Sensitivity (<i>CYP2C9</i> &amp; <i>VKORC1</i> SNP Analysis)</li> <li><input type="checkbox"/> 2400 <i>UBE3A</i>-Related Angelman Syndrome</li> </ul>	<p style="text-align: center;"><b>NEUROLOGY / INTELLECTUAL DISABILITY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8630 XLMR Evaluation (Steps 1 and 2) XLMR Optimized 180K Oligo Array Plus™ Step 1 XLMR Next Gen SuperPanel™ If Step 1 is negative</li> </ul> <p>Auto-reflex option below</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8628 XLMR Comprehensive Evaluation (Steps 1-4) We will only reflex if necessary Routine Karyotype—Blood Chromosomes Step 1 Fragile X DNA Analysis Step 2 XLMR Optimized 180K Oligo Array Plus™ Step 3 XLMR Next Gen SuperPanel™ Step 4</li> </ul> <p>To order any test individually or in another order, check above and indicate the order</p> <p>Individual Test Options Below</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 3000 XLMR Optimized 180K Oligo Array Plus™</li> <li><input type="checkbox"/> 8626 XLMR Next Gen SuperPanel™</li> <li><input type="checkbox"/> 3664 Routine Blood Chromosomes</li> <li><input type="checkbox"/> 2980 Fragile X DNA Analysis</li> <li><input type="checkbox"/> 3020 FRAXE (<i>FMR2</i>) DNA Analysis</li> </ul>
<p style="text-align: center;"><b>HEREDITARY HEMORRHAGIC TELANGIECTASIA (HHT)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8660 Ambry SEQUENCE™ HHT (All genes, Steps 1-3)</li> <li><input type="checkbox"/> 1683 HHT Full Gene Sequence (<i>ACVRL1, ENG</i>) Step 1</li> <li><input type="checkbox"/> 1681 HHT Deletion/Duplication (<i>ACVRL1, ENG</i>) Step 2</li> <li><input type="checkbox"/> 1684 SMAD4-Related HHT (<i>SMAD4</i>) Step 3</li> <li><input type="checkbox"/> 1680 HHT AMPLIFIED™ (<i>ACVRL1, ENG, Del/Dup</i>)</li> </ul>	<p><b>CLINICAL NOTES or INSTRUCTIONS</b></p>
<p><b>Maternal Cell Contamination (MCC, run concurrently with requested test)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1260 MCC for amniotic fluid culture or cvs</li> <li><input type="checkbox"/> 1262 MCC Reference for maternal blood sample</li> </ul>	<p style="text-align: center;"><b>RETT SYNDROME</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8200 Ambry SEQUENCE™: Rett Syndrome (<i>MECP2, CDKL5</i>)</li> <li><input type="checkbox"/> 2026 <i>MECP2</i> AMPLIFIED™ (Gene Sequence reflex to Del/Dup)</li> <li><input type="checkbox"/> 2020 <i>MECP2</i> Gene Sequence Analysis</li> <li><input type="checkbox"/> 2022 <i>MECP2</i> Deletion/Duplication</li> </ul>
<p style="text-align: center;"><b>NOONAN/LEOPARD SYNDROME</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8400 Ambry SEQUENCE™: All Genes (Steps 1 and 2)</li> <li><input type="checkbox"/> 2280 <i>PTPN11</i>-Related Disorders _____ Step 1</li> <li><input type="checkbox"/> 2300 <i>SOS1</i>-Related Syndrome _____</li> <li><input type="checkbox"/> 2320 <i>RAF1</i>-Related Noonan Disorders _____ Step 2</li> <li><input type="checkbox"/> 2340 <i>KRAS</i>-Related Noonan Disorders _____</li> <li><input type="checkbox"/> 8460 LEOPARD Syndrome (<i>PTPN11</i>, partial <i>RAF1</i>)</li> </ul>	<p style="text-align: center;"><b>ADDITIONAL NOTES OR CLINICAL FINDINGS</b></p>
<p><b>SPECIFIC MUTATION / GENE ANALYSIS</b></p>	
<p><b>Gene Sequence Analysis</b>      <input type="checkbox"/> Gene name: _____</p> <p><b>Single Mutation Analysis</b>    <input type="checkbox"/> Gene name: _____</p> <p>Mutation 1: _____ Mutation 2: _____ Mutation 3: _____</p>	
<p><b>Reporting Options</b>    <input type="checkbox"/> Report Amino Acid changing polymorphisms (silent polymorphisms available on request)</p>	

## Patient Consent Molecular Genetic Testing

**Test Purpose:** The purpose of this molecular genetic test is to ascertain if I am, **my child** is, or **my unborn child** is [please circle appropriate] carrying mutation(s) predisposing to or causing the specific disease or condition: \_\_\_\_\_.  
A supplemental disease description sheet is available from Ambry Genetics.

**Test Method:** The blood, body fluid, or tissue specimen submitted is required for isolation and purification of DNA for molecular genetic testing. The test will cover all disorders requested on the Ambry Genetics requisition form.

**Test Results:** I understand that due to the complexity of DNA based testing and the important implications of the test results, these results will be reported only through the patient's designated physician(s) or genetic counselor (where allowed) and that I must contact my provider to obtain the results of the test. The test results, in addition, could be released to all who, by law, may have access to such data.

I understand that if results of the molecular genetics tests are **positive**, I may be a carrier of, predisposed to, or have the specific disease or condition tested for and I may want to consider further independent testing, consult with my physician, or pursue genetic counseling. I understand that if results of the molecular genetics tests are **negative**, I may not be a carrier of, predisposed to, or have the specific disease or condition tested for and I may want to consider further independent testing, consult with my physician, or pursue genetic counseling. I understand the limitations of these results: the test results could be based upon probabilities, and may not provide a 100% definitive conclusion to either genetic disease predisposition or manifestations. I understand that the molecular genetic test may not generate results and that an additional blood, body fluid, or tissue sample may be needed to obtain accurate results. I understand that the molecular genetic test may not generate accurate results for the following reasons: sample mix-up, samples unavailable from critical family members, maternal contamination of prenatal samples, inaccurate reporting of family relationships, or technical problems, but not limited to these.

**Ambry's Rights:** Ambry reserves the right to: 1) suggest additional molecular testing if it would help in resolving the patient's clinical genotyping, 2) report additional testing results (other than requested) if they are clinically relevant to the patients and their families, and 3) refuse testing if one of the conditions in the Patient Consent form is not met.

**Use of Specimens:** After testing is completed, I understand that my blood, body fluid or tissue specimens may be disposed of or retained indefinitely for research, test validation, and/or education by Ambry Genetics, as long as my privacy is maintained. I understand that no compensation will be given nor will funds be forthcoming due to any invention(s) resulting from research and development using the specimens submitted. I understand that I may refuse to submit my specimen for use in this way and may withdraw my consent at anytime by contacting the medical director. I understand that my refusal to consent to medical research will not affect my results. Indicate consent or denial below. If a box is not marked consent is implied.

I consent to the use of my sample for research.     YES     NO

**Financial Responsibility:** I understand that if test cancellations are received prior to test set-up, processing will be honored at no charge. I understand that when requests for test cancellation are received after set-up, a cancellation report will be generated and a set-up fee will be charged. Once testing is initiated cancellation is not possible. I understand that I am responsible for all charges for testing and will be contacted for payment in the event my health plan does not reimburse for the test or Ambry Genetics does not receive a response from my health plan in a reasonable length of time.

I have read or have had read to me all of the above statements and understand the information regarding molecular genetics testing and have had the opportunity to ask questions I might have about the testing, the procedure, the risks, and the alternatives prior to my informed consent. I agree to have the molecular genetic testing.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name (please print):** \_\_\_\_\_