

**CARRIER SCREEN / PRENATAL 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 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 Direct Tissue <input type="checkbox"/> Other: _____	▶ <b>Previous Test History</b> Previously Detected Mutations: _____ Testing Lab: _____ Family previously tested at Ambry? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____      Relation: _____ ▶ <b>Indication for Testing</b> <input type="checkbox"/> Carrier Screening <input type="checkbox"/> AMA <input type="checkbox"/> Family History <input type="checkbox"/> Other _____ <b>ICD-9 codes:</b> _____
▶ <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. I confirm that this is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient. <b>Medical Professional Signature*</b> X _____      Date: _____ <small>* MD/DO, Clinical Nurse Specialist, Nurse-Midwives, Nurse Practitioner, Physician Assistant, Genetic Counselor (for certain states)</small> 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>Contact and Organization Information</b>	
▶ Authorized Ordering Physician      NPI#	
▶ Ph:      ▶ FX:	
▶ <b>Facility Name and Address</b> ID#	
Ordering Clinician Email:	
▶ <b>Additional Results Recipient</b>	
Medical Professional Name:	
Facility Name and Address <input type="checkbox"/> Same As Above	
▶ <b>List Relevant Clinical and or Ultrasound Findings:</b>	
(If Applicable) LMP:      EDC:      Gestational Age (weeks/days):	
▶ <b>Billing Information - Mandatory For Processing</b>	
<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)
Facility Name	Name of Insured      Relation to patient? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse
Address, City, State, Zip	Insurance Company Name and Address
Contact Person Name and Phone	Member ID #      Group #
	Authorization #      Date
▶ <b>Pre-Payment</b>	
Payment Type <input type="checkbox"/> Check <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> Visa <input type="checkbox"/> American Express	
Card Number	Exp Date
Cardholder Name	Amount
Signature	Date
▶ <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. A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients. Ambry will pre-verify patient insurance coverage and if estimated patient out-of-pocket costs exceed \$300, Ambry will not perform testing until patient is notified. Ambry Genetics will no longer perform Preverification for tests priced under \$200.	
Signature x _____      Date _____	

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



Patient Name

► Carrier Screen and Prenatal Test Directory

Requisition Form - (EDTA TUBE) unless otherwise indicated

- 8641 AmbrySCREEN™
- 4544 Fragile X DNA Analysis
- 3664 Routine Chromosome Analysis/Karyotype (1 Na Heparin Grn)
- 1808 Ashkenazi Jewish Panel™ with all 16 conditions
- 1804 Ashkenazi Jewish FlexPanel™ as marked below
  - Bloom (*BLM*)
  - Canavan (*ASPA*)
  - Cystic Fibrosis (*CFTR*)
  - Familial Dysautonomia (*IKBKAP*)
  - Fanconi Anemia Type C (*FANCC*)
  - Gaucher (*GBA*)
  - Glycogen Storage Disease 1a (*GSD1a*)
  - Joubert Syndrome (*TMEM216*)
  - Maple Syrup Urine Disease Type 1a and 1b (*BCKDHA/BCKDHB*)
  - Maple Syrup Urine Disease Type 3 (*DLD*)
  - Mucopolidosis Type IV (*MLDV*)
  - Nemaline Myopathy (*NEB*)
  - Niemann-Pick A (*SMPD1*)
  - Tay-Sachs (*HEXA*)
  - Usher Syndrome Type 1F (*PCDH15*)
  - Usher Syndrome Type III (*CLRN1*)
- 1007 *CFTR* Amplified (*CFTR* gene sequence and deletion/duplication concurrent)
- 1006 *CFTR* Amplified (*CFTR* gene sequence reflex deletion/duplication)
- 1018 *CFTR* Screening Panel (CF102)
- 2000 *CFTR* Screening Panel (CF33)
- 5240 Tay-Sachs Enzyme Assay (*HEXA* Leukocytes)
- 5220 Y Chromosome Microdeletion Analysis
- 3753 Spinal Muscular Atrophy (SMA) Carrier Test (Deletion Analysis)  
**1 Extra EDTA Tube Required (3-5cc)**

**Thrombophilia (5140)** (1 EDTA Lavender Top)

- 5141 Factor II (Prothrombin G20210A)
- 5143 Factor V (Leiden)
- 5145 *MTHFR* (C677T and A1298C)

**Maternal Cell Contamination**

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

**Additional History:**

**SPECIFIC MUTATION / GENE ANALYSIS**

- Gene Sequence Analysis (GSA)
- Single Site-Mutation Analysis (SMA)
- Single Site-Del/Dup Analysis

Gene Name: \_\_\_\_\_ Mutation(s): \_\_\_\_\_

Gene Name: \_\_\_\_\_ Mutation(s): \_\_\_\_\_

- Positive Control Not Available
- Positive Control Sent / To Be Sent

The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory: 1) Proband report (mandatory) and 2) Positive Control (recommended).

ACMG guidelines, CAP, and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence alteration. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.

**Reporting Options**  Report Amino Acid changing polymorphisms (silent polymorphisms available on request)

**REVERSE SIDE MUST BE COMPLETED FOR PROCESSING**