Ambry Genetics®

CARRIER SCREEN / PRENATAL TEST REQUISITION

Arrows "►" Mandatory for Processing

Contact and Organization Information

► Authorized Ordering Physician NPI#

► Ph: ► FX:

► Facility Name and Address ID#

Ordering Clinician Email:

Additional Results Recipient

Medical Professional Name:

Facility Name and Address ☐ Same As Above

► Form Completed by **► Phone**

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.

Medical Professional Signature* Mandatory for Medicare/Medicaid

X_____________________________ Date: ________________

* MD/DO, Clinical Nurse Specialist, Nurse-Midwives, Nurse Practitioner, Physician Assistant

Does this patient give consent to the use of their sample for research?
☐ Yes ☐ No Consent is implied if a box is not marked

Patient Information

► DOB MM - DD - YEAR | **► Last Name** | **► First Name** | M Initial

► Gender ☐ F ☐ M

► Street Address, City, State, Zip

► Ethnicity
☐ African American ☐Asian
☐ Caucasian
☐ Hispanic
☐ Jewish (Ashkenazi)
☐ Specify:_______________

► Home Phone Work/Cell

Specimen

► Collection Date:______________________

Specimen ID:______________________

MR#:______________________________

Specimen Type (See Requirements

☐ Blood ☐ Blood Spot ☐ DNA

☐ Cultured Amniocytes

☐ Cultured CVS ☐ CVS Direct Tissue

☐ Other:___________________________

Previous Test History

Previously Detected Mutations:_______________

Testing Lab:______________________________

Family previously tested at Ambry? ☐ Yes ☐ No

Name:_______________ Relation:______________

► Indication for Testing

☐ Carrier Screening ☐ AMA

☐ Family History ☐ Other _________________

ICD-9 codes:______________________________

List Relevant Clinical and or Ultrasound Findings:

(If Applicable) LMP: EDC: Gestational Age (weeks/days):

Billing Information - Mandatory For Processing

☐ **Bill Facility** ☐ same as ordering facility

Facility Name

Address, City, State, Zip

Contact Person Name and Phone

☐ **Bill Insurance** Include card copy (both sides)

Name of Insured | Relation to patient? ☐ Self ☐ Parent ☐ Spouse

Insurance Company Name and Address

Member ID # | Group #

Authorization # | Date

☐ **Pre-Payment**

Payment Type ☐ Check ☐ Mastercard ☐ Discover ☐ Visa ☐ American Express

Card Number | Exp Date

Cardholder Name | Amount

Signature | Date

Patient Acknowledgement 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 $350, 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

Ambry Genetics®

Patient Name

► Carrier Screen and Prenatal Test Directory — **Requisition Form -** (EDTA TUBE) unless otherwise indicated

- ☐ 8640 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*)
  - ☐ Mucolipidosis 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)

Prenatal Studies
- ☐ 3686 Amniotic Fluid (AF) Chromosome Analysis/Karyotype with AF– AFP Analysis (AChE according to Protocol)
- ☐ 3744 Aneuploidy Screen by FISH (13, 18, 21, X, Y)
- ☐ CALL Other Prenatal FISH (Specify): ____________________
- ☐ 3700 CVS Chromosome Analysis/Karyotype

Maternal Cell Contamination
- ☐ 1260 MCC for amniotic fluid culture or CVS (run concurrently with test)

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

Toll Free 866 262 7943 | Ph 949 900 5500 | Fx 949 900 5501 | www.ambrygen.com | 100 Columbia #200 | Aliso Viejo, CA 92656