Ambry Genetics

# Neurology Test Requisition Form

**COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS**

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

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

1. Clinic Notes 2. Pedigree 3. Insurance Card

## COLLECTION DATE (REQUIRED)

If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)

## 2. PATIENT INFORMATION

Legal Name (Last, First, MI) | Date of Birth (MM/DD/YY) | Sex Assigned at Birth ☐F ☐M | Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

Genetic Ancestry: ☐Ashkenazi Jewish ☐Asian ☐Black/African American ☐French Canadian/Cajun ☐Hispanic/Latino ☐Mediterranean ☐Middle Eastern ☐Native American ☐Pacific Islander ☐Portuguese ☐White ☐Unknown ☐Other: | MRN

Address | City | State | Zip

Mobile # | Email

## SPECIMEN INFORMATION (Please see ambrygen.com/specimen-requirements for details)

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

Specimen ID | Medical Record #

Collection Assistance: ☐Phlebotomy draw* ☐ Send saliva kit to patient ☐ Send buccal kit to patient | ☐ Insurance preverification first (available for ExomeNext and SNP array 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.*

## INDICATION(S) FOR TESTING

ICD-10 code(s):

Will medical management change depending upon the results of the test? ☐ Yes ☐ No

## PATIENT HISTORY ☐ No personal history of neurological disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, due date: Upcoming procedure date:

**Reasons for Testing:**

**Birth and Neonatal History** ☐N/A
Gestational age at birth: _____ Birth weight: _____
Head circumference at birth (if available):_____

**Developmental History** ☐N/A
Developmental delay: ☐Yes ☐No ☐Unknown
Type of delay (choose all that apply): ☐Motor ☐Language ☐Global
Intellectual disability: ☐Yes ☐No ☐Unknown
Regression or plateau: ☐Yes ☐No ☐Unknown
Does patient meet DSM-V diagnostic criteria for an autism spectrum disorder? ☐Yes ☐No

**Seizure History** ☐N/A Age at first unprovoked seizure: _____
Has this patient been diagnosed with an epilepsy syndrome? ☐Yes ☐No ☐Unknown
If yes, please specify: _____

**Other History** ☐N/A
Hypo-/hyperpigmentation: ☐Yes ☐No Telangiectasias: ☐Yes ☐No
Other skin abnormality, type: _____
Brain tumor, type: _____ Nerve tumor, type: _____
Other tumor, type: _____

**Other Clinical Findings (choose all that apply)**

| | | |
|---|---|---|
| ☐Ataxia | ☐Macrocephaly | ☐Psychiatric disorder |
| ☐Dysmorphic features | ☐Microcephaly | ☐Spasticity |
| ☐Hearing disorder | ☐Migraine | ☐Vision disorder |
| ☐Hypotonia | ☐Movement disorder | |

**Prior Testing:**

## 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, PRE-TEST GENETIC COUNSELING, 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. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.

*Signature Required for Processing* Medical Professional Signature: Date:

## ☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child | Name and DOB of Policy Holder (if not self)

Insurance Company | Policy # | HMO Auth #

**Special Billing Notes:**

## ☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*

Address

Contact Name

Phone Number | E-mail/Fax

## ☐ PATIENT PAYMENT

☐Check (Payable to Ambry Genetics)
☐Credit Card (Call 949-900-5795)

**Patient Acknowledgement:** 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 Ambry Genetics Corporation (Ambry), authorize Ambry 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 Ambry money received from my health insurance company.

☐ I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at https://www.ambrygen.com/legal/notice-of-privacy-practices.

**For patient payment by credit card:** I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambry'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 Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

**For NY Residents:** ☐ By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

*Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent*: Patient Signature Date:

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Patient Name: _____ DOB: _____

# Neurology Test Requisition Form

**For Reflex or Concurrent Testing:**

Test 1: _____ ☐ Reflex to ☐ Concurrent with Test 2: _____ ☐ Reflex to ☐ Concurrent with Test 3: _____

See Reflex or Concurrent Testing section of the Supplemental Information page.

| Check | Test Name | Test Code | Description |
|---|---|---|---|
| **Exome** | | | |
| ! | **REQUIRED: Select a Primary Test Order** | | |
| ☐ | ExomeNext®-*Trio* | 9995 | Trio exome sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext®-*Trio* plus mtDNA | 9996 | Trio exome sequencing plus mtDNA sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext®-*Duo* | 9991 | Duo exome sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext®-*Duo* plus mtDNA | 9992 | Duo exome sequencing plus mtDNA sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext®-*Proband* | 9993 | Proband only exome sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext®-*Proband* plus mtDNA | 9994 | Proband only exome sequencing plus mtDNA sequencing<br>Secondary Findings*: ☐ Opt-out |
| ☐ | ExomeNext-*Rapid*® *(Institutional billing or patient payment only)* | 9999R | Rapid Trio exome sequencing plus mtDNA sequencing<br>Secondary Findings*: ☐ Opt-out |
| **ExomeNext Supplemental Test Options** | | | |
| ☐ | ExomeReveal™ | 9990 | RNA analysis available with all ExomeNext orders except for ExomeNext-*Rapid*, EDTA and PAXgene RNA tubes required |
| **Fragile X syndrome and Chromosomal Microarray** | | | |
| ☐ | Fragile X syndrome | 4544 | *FMR1* repeat expansion analysis and methylation studies |
| ☐ | SNP Array | 5490 | Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes) |
| ☐ | Familial targeted microarray | 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.<br>Name of proband tested at Ambry:<br>_____ |

| Check | Test Name | Test Code | Description |
|---|---|---|---|
| **Epilepsy** | | | |
| ☐ | EpiRapid® | 6862 | 22 epilepsy genes with treatment associations |
| ☐ | EpilepsyNext® | 6864 | 124 genes for epilepsy |
| ☐ | EpilepsyNext-*Expanded*™ | 6865 | >950 genes associated with seizures, primarily with neonatal to childhood onset** |
| **Migraine** | | | |
| ☐ | Familial hemiplegic migraine | 6866 | *ATP1A2, ATP1A3, CACNA1A, PRRT2, SCN1A, SLC1A3, SLC2A1* |
| **Neurodevelopmental Disorders** | | | |
| ☐ | AutismNext® | 6863 | 72 genes for non-syndromic autism spectrum disorders and/or intellectual disability |
| ☐ | Autism, macrocephaly | 2106 | *PTEN* |
| ☐ | NeurodevelopmentNext™ | 6861 | 202 genes known to cause developmental delay, intellectual disability, and/or autism spectrum disorders |
| **Hereditary Neuropathy** | | | |
| ☐ | Familial transthyretin amyloidosis | 1560 | *TTR* |

**Neurocutaneous/Neuro-Oncology Disorders**

Testing is available for Neurocutaneous and Neuro-Oncology disorders (such as neurofibromatosis and tuberous sclerosis) using our Cancer or Comprehensive requisition forms available at: www.ambrygen.com/providers/forms

**SINGLE SITE ANALYSIS** (Please include a copy of relative's report)

Gene(s): _____ Mutation(s): _____

Relative Name: _____

Relationship to Relative:_____ Accession # (If tested at Ambry): _____

Positive control sample: ☐ Will be provided ☐ Already at Ambry ☐ Not available

**FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED**

Both test codes required for fetal specimens.

☐ 1260 MCC for fetal specimen or cord blood

☐ 1262 MCC Reference for maternal blood sample (No Charge)

* Secondary Findings: If box is left unchecked, the ACMG recommended list of Secondary Findings will be reported.

** Gene lists for EpilepsyNext-*Expanded* are updated annually due to proactive review of current literature using an internal, peer-reviewed clinical validity scheme (Smith ED, Radtke K, Rossi M, *et al.* 2017 Human mutation 38(5):600-608). The patient's test report will include a list of genes evaluated. For up-to-date gene lists, visit ambrygen.com

☐ **Opt-in to Reporting of Variants of Unknown Significance (VUS)**

*For patients undergoing an epilepsy, neurodevelopmental disorder, or familial hemiplegic migraine panel, checking this box indicates that VUS identified on the test(s) ordered above will be reported for this patient. If you do not check this box, VUS will not be reported.*

☐ **Parental samples provided for cosegregation**

*Cosegregation testing of family members is available for the following panels: EpiRapid, EpilepsyNext, EpilepsyNext-Expanded, AutismNext, NeurodevelopmentNext, Familial hemiplegic migraine*

**FAMILY MEMBER INFORMATION** (Completion of this section is required for order including parental samples. If available, please also submit a 3-generation pedigree)

| Relative | Name | DOB | Affected status**** | Samples included? |
|---|---|---|---|---|
| | | | ☐ Yes ☐ No | ☐ |
| | | | ☐ Yes ☐ No | ☐ |

**** *If affected, please list symptoms and age at diagnosis:*

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| PROBAND'S CLINICAL OVERVIEW (Check yes for all that apply) | | |
|---|---|---|
| ☐ Yes ☐ No Audiologic/Otolaryngologic | ☐ Yes ☐ No Hematologic | ☐ Yes ☐ No Ophthalmologic |
| ☐ Yes ☐ No Cardiovascular | ☐ Yes ☐ No Immunologic/Infectious/Allergy | ☐ Yes ☐ No Pulmonary |
| ☐ Yes ☐ No Craniofacial | ☐ Yes ☐ No Metabolic/Biochemical | ☐ Yes ☐ No Renal |
| ☐ Yes ☐ No Dental | ☐ Yes ☐ No Movement Disorder | ☐ Yes ☐ No Tone abnormalities |
| ☐ Yes ☐ No Dysmorphic Features | ☐ Yes ☐ No Musculoskeletal/Structural | ☐ Yes ☐ No Hypotonia |
| ☐ Yes ☐ No Dermatologic | ☐ Yes ☐ No Multiple Congenital Anomalies | ☐ Yes ☐ No Hypertonia |
| ☐ Yes ☐ No Endocrine | ☐ Yes ☐ No Neurologic | |
| ☐ Yes ☐ No Fetal (*Please complete and attach "ExomeNext Prenatal Form"*) | ☐ Yes ☐ No Seizures/Epilepsy | |
| | ☐ Yes ☐ No Autism Spectrum Disorder | |
| ☐ Yes ☐ No Gastrointestinal | ☐ Yes ☐ No Developmental Delay/Intellectual disability | |
| ☐ Yes ☐ No Genitourinary | ☐ Yes ☐ No Ataxia/Spasticity | |
| ☐ Yes ☐ No Growth Disorders: | ☐ Yes ☐ No Psychiatric | |
| ☐ Yes ☐ No Undergrowth | ☐ Yes ☐ No Abnormal brain MRI | |
| ☐ Yes ☐ No Overgrowth | ☐ Yes ☐ No Obstetric | |
| ☐ Yes ☐ No Failure to thrive | ☐ Yes ☐ No Oncologic | |

## Supplemental Information

### Sample Requirements

Blood/saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. Please see ambrygen.com/specimen-requirements for details

Buccal swab samples from patients with a history of allogenic bone marrow or stem cell transplant should not be used for genetic testing. For these patients, an alternative specimen (e.g. cultured fibroblasts) is required. Testing on buccal swab samples from patients with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended. Please see ambrygen.com/specimen-requirements for details.

Fetal specimens, cord blood and POC will have maternal cell contamination (MCC) studies added for a charge. Maternal and fetal specimen required. Please see page 2 for MCC test codes.

#### Reflex or Concurrent Testing

Concurrent testing is when multiple tests are initiated at the same time. When multiple tests are ordered on the same test requisition form, testing will be run concurrently unless otherwise specified.

Reflex testing is when a subsequent test is initiated pending the outcome of the initial test. Reflex testing may result in delayed reporting of results.

For reflex test orders:

- Any diagnostic finding at any step will result in cancellation of any subsequent reflex tests.
- Non-diagnostic findings (including VUS or Uncertain results) will automatically reflex to the subsequent test.
- Secondary findings results do not impact whether a subsequent test is initiated or canceled.

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Patient Name: _____ DOB: _____

# ExomeNext Medical Necessity Form

## REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is ONLY required if you are requesting reflex to Exome sequencing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

   ☐ Yes, date performed: _____

   ☐ No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

   ☐ Multiple abnormalities affecting unrelated organ systems (please specify): _____

   OR two of the following:

   ☐ Abnormality affecting a single organ system(specify): _____

   ☐ Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)

   ☐ Family history strongly implicating a genetic etiology (please specify findings and relationships)

   ☐ Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

   ☐ Yes (please describe): _____

   ☐ No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

   ☐ Chromosomal microarray

   ☐ Single gene test(s): _____

   ☐ Multigene panel(s): _____

   ☐ Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

   ☐ Imaging study: _____

   ☐ Surgery: _____

   ☐ Biopsy: _____

   ☐ Other: _____

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