Ambry Genetics

Cardiovascular Test Requisition Form - Page 1 of 3

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

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	Preferred Billing ☐Insurance ☐Self-pay ☐Institutional

FAMILY HISTORY* ☐ None (maternal) ☐ None (paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

**Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigrees and other clinical family history notes should be supplied as well when sending in your order.*

Relation to patient	Mat	Pat	H/o cardio disease	Dx age	Relation to patient	Mat	Pat	H/o cardio disease	Dx age
	☐	☐				☐	☐		
	☐	☐				☐	☐		

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

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

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)	Specimen ID ☐ Send saliva kit to patient	Medical Record #

☐ Specimen is post-mortem Date of death: _____ Specimen Type: _____

*** Fetal specimens, cord blood and POC will have maternal cell contamination studies added for a charge. Maternal and fetal specimen required. Please see page 2 for Maternal Cell Contamination sample submission test codes.*

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.

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 Provider Name (Last, First), Ambry Number , NPI		
☐	☐	☐

Additional Results Recipients

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.

Patient Signature (I agree to terms above): Date:

Ambry Genetics®

Patient Name: _____ DOB: _____

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INDICATIONS FOR TESTING (Check all that apply)

☐ Diagnostic ☐ Family history ☐ Positive or normal control ☐ Other_____ ICD-10 code(s): _____

Will medical management change depending upon the results of the test? ☐ Yes ☐ No ☐ STAT TEST: Date results needed (if known):_____

CLINICAL HISTORY (Please supply clinic notes and pedigree)

☐ No personal history of cardiovascular disease

Sudden cardiac arrest ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

Syncope ☐ Y ☐ N (if yes): # Episodes:_____ Age first incident: _____

History of cardiomyopathy ☐ Y ☐ N Age at dx:_____

Type(s) of cardiomyopathy: _____

History of Arrhythmia ☐ Y ☐ N Age at dx: _____

Type(s) of Arrhythmia: _____

☐ Clinical diagnosis of Marfan Syndrome or other connective tissue disorder

☐ Aortic Aneurysm/Dilation Age at dx:_____ z-score:_____

☐ Other Aneurysm Location:_____ Age at dx:_____

☐ Aortic/Vascular Dissection Location:_____Age at dx:_____

☐ History of familial hypercholesterolemia

☐ Other history: _____

CLINICAL TESTING AND PROCEDURES

LDL-C: _____ Total Cholesterol:_____ Age at Testing:_____

Procedures (*e.g.*: EKG, ECHO, etc.) Age: _____ Result (*e.g.*: LVIDd, PWd, Qtc, etc): _____ Type: _____

Cardiovascular Device implant (eg: Pacemaker, ICD, LVAD, etc.): Age at implantation: _____ Type: _____

PREVIOUS GENETIC TESTING (Please include copies of any previous test results) ☐ No previous molecular and/or genetic testing

Test	Laboratory	Results

CARDIOVASCULAR TEST OPTIONS

Check to order	Test Name	Test Code	Description
Cardiomyopathy Panels			
☐	HCMNext®	8936	30 genes for hypertrophic cardiomyopathy
☐	HCMNext Reflex	8883	*MYBPC3, MYH7* reflex to HCMNext
☐	DCMNext®	8884	37 genes for dilated cardiomyopathy
☐	CMNext®	8887	56 genes for hereditary cardiomyopathy
☐	ARVCNext®	8904	11 genes for arrhythmogenic right ventricular cardiomyopathy
Arrhythmia Panels			
☐	LongQTNext	8890	17 genes for long QT, Brugada and short QT syndromes
☐	RhythmNext®	8900	42 genes for long QT syndrome, Brugada and short QT syndromes, CPVT and ARVC
☐	CPVTNext®	8902	4 genes for catecholaminergic polymorphic ventricular tachycardia
Aneurysms and Related Disorders			
☐	TAADNext®	8789	35 genes for thoracic aortic aneurysms/ dissections, Marfan syndrome, Ehlers-Danlos and related disorders
☐	Marfan reflex to TAADNext	8783	*FBN1* reflex to TAADNext

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)

SPECIFIC 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

Check to order	Test Name	Test Code	Description
Comprehensive Cardiovascular Panels			
☐	CardioNext®	8911	92 genes for hereditary cardiomyopathies and arrhythmias
☐	CustomNext-*Cardio*®	9520	Up to 167 genes related to hereditary cardiomyopathies, arrhythmias, TAAD, HHT, Noonan, and lipidemias. Required: completed CustomNext-*Cardio* supplemental form. ambrygen.com/forms
Familial Hypercholesterolemia and Lipid Disorders			
☐	FHNext®	8680	4 genes (*APOB, LDLR, LDLRAP1, PCSK9*)
☐ Check this box if you would like to have the *SLCO1B1* c.521T>C polymorphism reported with FHNext, which has been associated in medical literature with statin-induced myopathies			
☐	FCSNext (Familial Chylomicronemia Syndrome)	8920	*APOA5, APOC2, GPIHBP1, LMF1, LPL*
☐	Sitosterolemia	8930	*ABCG5, ABCG8*
Hereditary Hemorrhagic Telangiectasia (HHT)			
☐	HHTNext®	8672	*ACVRL1, ENG, EPHB4, GDF2, RASA1, SMAD4*
Noonan Syndrome			
☐	NoonanNext	8402	18 genes for RASopathies
Other			
☐	Transthyretin amyloidosis	1560	*TTR*
☐	SNP Array***	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)

OTHER ORDER

Test Code: _____Test Name: _____

*** *Buccal swab accepted for SNP Array*

For more information visit ambrygen.com

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Supplemental Information

Specimen 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. 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.

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MKT-SPEC-TRF-20002-EN v22 06.21.24