Ambry Genetics®
A TEMPUS COMPANY

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

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)

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

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 GenomeNext™)

** 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

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

I confirm that the genetic test ordered is medically appropriate. All information on this TRF is true to the best of my knowledge. I also confirm that the patient has consented to proceed with genetic testing, including the transfer and processing of their sample and personal/sensitive information in the United States. 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.

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.

For NY Residents: ☐ I understand that New York State law requires Ambry Genetics to destroy my sample at the end of the testing process or not more than sixty days after the sample was taken. By checking this box, I agree that Ambry Genetics will instead retain my sample for at least 6 months after the testing above has been completed, and may (a) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (b) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

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

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Patient Name: _____ DOB: _____

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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: _____

Previously Reported Variants: *See instructions for reporting of Previously Reported Variants on the Supplemental Information Page*

Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____
Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____
Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____

Known Familial Variant: Gene: _____ Variant (c. and/or p.): _____ Testing Lab:_____ Ambry ID: _____

PROBAND'S CLINICAL OVERVIEW (Check yes for all that apply)

☐Yes ☐No Audiologic/Otolaryngologic
☐Yes ☐No Cardiovascular
☐Yes ☐No Craniofacial
☐Yes ☐No Dental
☐Yes ☐No Dysmorphic Features
☐Yes ☐No Dermatologic
☐Yes ☐No Endocrine
☐Yes ☐No Fetal (*Please complete and attach "ExomeNext Prenatal Form"*)
☐Yes ☐No Gastrointestinal
☐Yes ☐No Genitourinary
☐Yes ☐No Growth Disorders:
- ☐Yes ☐No Undergrowth
- ☐Yes ☐No Overgrowth
- ☐Yes ☐No Failure to thrive

☐Yes ☐No Hematologic
☐Yes ☐No Immunologic/Infectious/Allergy
☐Yes ☐No Metabolic/Biochemical
☐Yes ☐No Movement Disorder
☐Yes ☐No Musculoskeletal/Structural
☐Yes ☐No Multiple Congenital Anomalies
☐Yes ☐No Neurologic
- ☐Yes ☐No Seizures/Epilepsy
- ☐Yes ☐No Autism Spectrum Disorder
- ☐Yes ☐No Developmental Delay/Intellectual disability
- ☐Yes ☐No Ataxia/Spasticity
- ☐Yes ☐No Psychiatric
- ☐Yes ☐No Abnormal brain MRI

☐Yes ☐No Obstetric
☐Yes ☐No Oncologic

☐Yes ☐No Ophthalmologic
☐Yes ☐No Pulmonary
☐Yes ☐No Renal
☐Yes ☐No Tone abnormalities
- ☐Yes ☐No Hypotonia
- ☐Yes ☐No Hypertonia

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Patient Name: _____ DOB: _____

Neurology Test Requisition Form

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

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

Check	Test Name	Test Code	Description
Exome			
!	**REQUIRED: Select a Primary Test Order**		
☐	ExomeNext® ☐ Proband only ☐ Duo ☐ Trio	9900	Exome sequencing
☐	ExomeNext-*Rapid*®	9999-R	Rapid trio exome sequencing including a defined list of established disease-causing variants in the mitochondrial DNA (mtDNA)
ExomeNext Supplemental Test Options *(Primary test order required. See descriptions for details.)*			
	ACMG Secondary Findings* ☐ Decline	9920	Analysis of genes included in the ACMG Recommended List of secondary findings. Secondary findings results are available free of charge for the proband and each family member who is fully sequenced as part of the duo/trio.
☐	ExomeReveal® RNA Analysis	9990	RNA analysis is available with all ExomeNext orders except for ExomeNext-*Rapid*. EDTA and PAX-gene RNA tubes are required.
☐	Mito DNA	9900-M	Analysis of a defined list of established disease-causing variants in the mitochondrial DNA (mtDNA)
Genome			
!	**REQUIRED: Select a Primary Test Order**		
☐	GenomeNext™ ☐ Proband only ☐ Duo ☐ Trio	7000	Genome sequencing including sequencing of mitochondrial DNA (mtDNA)
GenomeNext Supplemental Test Options *(Primary test order required.)*			
	ACMG Secondary Findings* ☐ Decline	7002	Analysis of genes included in the ACMG Recommended List of secondary findings. Secondary findings results are available free of charge for the proband and each family member who is fully sequenced as part of the duo/trio.
☐	GenomeReveal™ RNA Analysis	7004	RNA analysis is available with all GenomeNext orders. EDTA and PAX-gene RNA tubes are required. Genome Reveal will be added automatically if a PAX tube is provided.
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)

**Secondary Findings: Check "decline" to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported.*

Check	Test Name	Test Code	Description
Epilepsy			
☐	EpilepsyNext®	6864	Multigene panel test for epilepsy
☐	EpilepsyNext-*Expanded*™	6865	Multigene panel test for genes associated with seizures, primarily with neonatal to childhood onset
Neurodevelopmental Disorders			
☐	AutismNext®	6863	Multigene panel test for non-syndromic autism spectrum disorders and/or intellectual disability
☐	Autism, macrocephaly	2106	*PTEN*
☐	NeurodevelopmentNext™	6861	Multigene panel test for 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

KNOWN VARIANT ANALYSIS (Please include a copy of relative's report)

Gene(s): _____ Variant(s) (c. and/or p.): _____

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.c

☐ 1260 MCC for fetal specimen or cord blood

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

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

For patients undergoing an epilepsy or neurodevelopmental disorder 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: EpilepsyNext, EpilepsyNext-Expanded, AutismNext, NeurodevelopmentNext

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:*

Supplemental Information

Electronic ordering is also available via AmbryPort®. Please visit https://portal.ambrygen.com/login to log in to the online portal.

Neurology Multi-Gene Tests

For current neurology panel gene content, please visit www.ambrygen.com/providers/neurology/test-menu (linked to QR code below)

Scan for current neurology panel gene content

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 3 for MCC test codes. Fetal specimens, cord blood, and POC are not accepted sample types for GenomeNext™.

Known variant analysis should be accompanied by a copy of the original testing report or internal Ambry testing information (internal Ambry ID, Name/DOB). Please review information about positive controls and other specifics at ambrygen.com/knownvariantanalysis.

Previously Reported Variants

ExomeNext® or GenomeNext™ report comments about the presence or absence of a variant previously reported **in the patient** require the "Previously Reported Variant" section of this form to be completed accurately, including an internal Ambry reference ID and/or a copy of the positive family member's lab report. Acceptable types of Ambry identifiers include:

- Accession number
- Order number
- Name and date of birth

Previously reported variant requests without an internal Ambry reference ID or positive lab report will not receive a variant-specific report comment.

Variant-specific report comments about the presence or absence of a variant previously reported **in a family member** are not included in ExomeNext, GenomeNext, or Neurology panel reports.

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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