Ambry Genetics
A TEMPUS COMPANY

Clinical Genomics Family Member Test Requisition Form

COMPLETE TO SUBMIT FAMILY MEMBERS FOR EXOME OR GENOME ORDERS

All family member specimens must be received within 4 weeks of order to be included in analysis

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)

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

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

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

☐ Current diagnosis of heme malignancy, Type:

Specimen ID	Medical Record #

Collection Assistance: ☐Phlebotomy draw** ☐Insurance preverification first ☐Send saliva kit to patient ☐Send buccal kit to patient

***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.*

CLINICAL INFORMATION

Is family member affected with the same phenotype as the proband? ☐Yes ☐No ☐Partially ☐Possibly, describe: _____

TEST MENU

☐ Family member for ExomeNext® (no charge) ☐ Family member for GenomeNext™ (no charge)

☐ Family member for ExomeNext-*Rapid*® (no charge) ☐ Other _____(Test Code/Test Name)

Proband Name: _____

Relationship to proband: _____

SECONDARY FINDINGS

Secondary findings results are only available for each family member who is fully sequenced as part of the duo/trio.

Check "decline" to opt-out of the ACMG Recommended List of secondary findings. If left unchecked, secondary findings will be reported for this family member.

☐ Decline

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

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

By signing and/or submitting the order: I certify that (1) the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s); (2) the ordered test(s) are medically necessary and will inform the patient's treatment plan; and (3) the patient has provided informed consent that meets the requirements of applicable law for Tempus/Ambry or its reference lab to: (a) collect and use the patient's samples (including genetic material) and health information and perform the ordered test(s); (b) obtain, receive, and release health information (including test results) as necessary for reimbursement or the processing of insurance claims; (c) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (d) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law. I agree to allow Tempus/Ambry 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:

Family Member Acknowledgement: I affirm that the medical professional listed above has offered genetic counseling and has reviewed with me the exome or genome sequencing process prior to testing, and I would like to proceed with test processing. I understand that the exome or genome testing is being performed in order to assist analysis for my family member (proband), that a primary report will only be generated for the proband, and that it may be possible to infer information about my results based on the proband's report.

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.

If family member signature is not completed below, the medical professional listed above affirms the family member has given consent for genetic testing to be performed and the signed consent form is on file.

Family Member/Guardian Signature:_____ Date:_____

For all exome or genome orders, Ambry includes testing for co-segregation analysis (aka: family testing for candidate alterations) if samples are sent before testing begins.

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Supplemental Information

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

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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