



# CARRIER SCREENING TEST REQUISITION

Arrows "▶" Mandatory for Processing

### Contact and Organization Information

▶ Authorized Ordering Physician NPI# \_\_\_\_\_

▶ Ph: \_\_\_\_\_ ▶ FX: \_\_\_\_\_

▶ Facility Name and Address \_\_\_\_\_ ID# \_\_\_\_\_

### 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 \_\_\_\_\_

### Additional Results Recipient

Medical Professional Name: \_\_\_\_\_

Facility Name and Address \_\_\_\_\_  Same As Above

Ph \_\_\_\_\_ Fx \_\_\_\_\_

### Specimen

▶ Collection Date: \_\_\_\_\_

Specimen ID: \_\_\_\_\_

MR#: \_\_\_\_\_

Specimen Type (See Requirements)

Blood  Blood Spot  DNA

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: \_\_\_\_\_

### 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.

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

**Medical Professional Signature** \_\_\_\_\_ Mandatory for New York State

X \_\_\_\_\_ Date \_\_\_\_\_

### List Relevant Clinical and or Ultrasound Findings:

(If Applicable) LMP: \_\_\_\_\_ EDC: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

### Billing Information - Mandatory For Processing

Bill Facility  same as ordering facility  Bill Insurance Include card copy (both sides)

Facility Name \_\_\_\_\_ Name of Insured \_\_\_\_\_ Relation to patient?  Self  Parent  Spouse

Address, City, State, Zip \_\_\_\_\_ Insurance Company Name and Address \_\_\_\_\_

Contact Person Name and Phone \_\_\_\_\_ 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.

Signature x \_\_\_\_\_ Date \_\_\_\_\_

### ▶ Test Directory

- 8640 AmbryScreen™
- 2980 Fragile X DNA Analysis
- 1800 Ashkenazi Jewish Panel™ with all 16 conditions
- 1808 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)  Tay-Sachs (HEXA)
  - Maple Syrup Urine Disease Type 1a and 1b (BCKDHA/BCKDHB)
  - Maple Syrup Urine Disease Type 3 (DLD)  Mucopolidiosis Type IV (MLDV)
  - Nemaline Myopathy (NEB)  Niemann-Pick A (SMPD1)
  - Usher Syndrome Type 1F(PCDH15)  Usher Syndrome Type III (CLRN1)

- Sickle Cell Testing (1 EDTA Lavender Top)**
- 1040 Beta Thalassemia Plus (HBB)
  - 1002 508 FIRST™ (deltaF508, reflex to CF AMPLIFIED™)
  - 1006 CF AMPLIFIED™  Report PolyT / TG Status
- Thrombophilia (1 EDTA Lavender Top)**
- 5141 Factor II (Prothrombin G20210A)
  - 5143 Factor V (Leiden)
  - 5145 MTHFR (C677T and A1298C)