ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform cystic fibrosis testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR CYSTIC FIBROSIS (CF) TESTING

Patient's Name _____ Date of Birth_____ /_____/_____Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____Practice Specialty_____

Genetic Counselor _____ Counselor Phone (_____)_____

Is the patient pregnant? [ ] No [ ] Yes [ ] NA

Patient's Ethnicity (check all that apply)
[ ] African American [ ] Ashkenazi Jewish [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Middle Eastern [ ] Native American [ ] Other _____

Did the patient have a positive newborn screen for CF? [ ] No [ ] Yes **If yes, describe**_____

Does the patient have SYMPTOMS of CF? [ ] No [ ] Yes, check all that apply
[ ] Fetal echogenic bowel [ ] Chronic cough [ ] COPD [ ] Azoospermia
[ ] Meconium ileus [ ] Sinusitis [ ] Pseudomonas [ ] Unilateral absence of vas deferens
[ ] Nasal polyps [ ] Pancreatitis [ ] Pneumonia [ ] Bilateral absence of vas deferens
[ ] Failure to thrive [ ] Bronchiectasis [ ] Diabetes [ ] Other_____

Has SWEAT CHLORIDE testing been performed? [ ] No [ ] Yes [ ] Unknown
If yes, what was result? _____ [ ] normal (<40) [ ] borderline (40-60) [ ] elevated (>60) [ ] Unknown

Does the patient have a FAMILY HISTORY of CF? [ ] No [ ] Yes [ ] Unknown
If yes, what is the specific RELATIONSHIP of the family member to the patient? _____
Is the relative [ ] a healthy carrier [ ] affected with CF List the mutation(s) _____

Is the patient's REPRODUCTIVE PARTNER a CF carrier? [ ] No [ ] Yes List the mutation_____
Does the patient's reproductive partner have a FAMILY HISTORY of CF? [ ] No [ ] Yes [ ] Unknown
If yes, what is the specific RELATIONSHIP of the family member to the partner? _____
Is the relative [ ] a healthy carrier [ ] affected with CF

Has the patient undergone previous DNA testing for CF? [ ] No [ ] Yes [ ] Unknown
If yes, please describe test(s) and results_____

Circle the CF test below you intend to order.

2001933 (***CFTR)*** **32 Mutations**: Tests for 32 CF mutations. Clinical sensitivity for mutations is 94% in Ashkenazi Jews, 65% in African Americans, 89% in Caucasians, 73% in Hispanics, and 55% in Asian Americans.

2001968 (***CFTR)*** **32 Mutations with Reflex to Sequencing**: Tests for 32 CF mutations; gene sequencing performed if two mutations are not identified. Sensitivity is 97-98%. For individuals with classic or nonclassic CF symptoms.

0051110 (***CFTR)*** **Sequencing**: *CFTR* gene sequencing with a clinical sensitivity of 97-98%.

2001967 (***CFTR)*** **32 Mutations w/ Reflex to Sequencing w/ Reflex to Deletion/Duplication**: Tests 32 mutations reflexing to sequencing and deletion/duplication testing until two mutations are identified. Sensitivity is 99%.

0051640 ***(CFTR*****) Sequencing and with Reflex to Deletion/Duplication:** CFTR gene sequencing; if two mutations are not identified, deletion/duplication testing is performed. Sensitivity is 99%.

2001961 Familial Mutation, Targeted Sequencing: Tests for a previously identified familial mutation; copy of a relative's lab result is REQUIRED.

For questions, contact an ARUP genetic counselor at (800) 242-2787 ext. 2141

Master Label