

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FORM FOR CYSTIC FIBROSIS (CF) TESTING

Patient Name: _____ **Date of Birth:** _____
Sex Assigned at Birth: Female Male Intersex **Gender Identity (optional):** Female Male _____
Ordering Provider: _____ **Provider's Phone:** _____
Practice Specialty: _____ **Provider's Fax:** _____
Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity (check all that apply)

- Black/African American Asian Hispanic or Latino Native American or Other Pacific Islander
 Ashkenazi Jewish White Middle Eastern Other: _____

Is the patient pregnant? No Yes N/A

Does the patient have symptoms? No Yes (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Azoospermia | <input type="checkbox"/> COPD | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Bilateral absence of the vas deferens | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Fetal echogenic bowel | <input type="checkbox"/> Positive newborn screen |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Meconium ileus | <input type="checkbox"/> Pseudomonas |
| <input type="checkbox"/> Other symptoms: _____ | | |

Has sweat chloride testing been performed? No Yes Unknown

If yes, what was the result? normal (<30) borderline (30-60) elevated (>60) QNS Unknown

Has the patient undergone previous DNA testing for CF? No Yes Unknown

If yes, describe the test(s) and results: _____

Does the patient have a family history of CF? No Yes Unknown

If yes, specify the relationship of the family member to the patient: _____

Indicate if the relative is: a healthy carrier affected with CF List CF variant(s): _____

Is the patient's reproductive partner a CF carrier? No Yes If yes, list the variant: _____

Does the patient's reproductive partner have a family history of CF? No Yes Unknown

If yes, specify the relationship of family member(s) to the partner: _____

Is the partner's relative a healthy carrier or affected?

Master Label

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