

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 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
 Absence of the vas deferens COPD Meconium ileus Pseudomonas
 Bronchiectasis Failure to thrive Pancreatitis Other _____
 Chronic cough Fetal echogenic bowel Pneumonia _____

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? Unknown 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.

- 2013661 Cystic Fibrosis (CFTR) 165 Pathogenic Variants** - Tests for 165 pathogenic CF variants. Recommended for carrier screening in obstetric patients and as first line diagnostic test in symptomatic patients. Clinical sensitivity for carrier detection is 78% in African Americans, 96% in Ashkenazi Jews, 55% in Asian Americans, 92% in Caucasians and 80% in Hispanics.
- 2013663 Cystic Fibrosis (CFTR) 165 Pathogenic Variants with Reflex to Sequencing** - Tests for 165 pathogenic CFTR variants; gene sequencing performed if two pathogenic variants are not identified. Clinical sensitivity is 97%.
- 0051110 Cystic Fibrosis (CFTR) Sequencing** - CFTR gene sequencing; clinical sensitivity is 97%.
- 2013664 Cystic Fibrosis (CFTR) 165 Pathogenic Variants w/Reflex to Sequencing w/Reflex to Deletion/Duplication** - Tests 165 pathogenic variants reflexing to sequencing and deletion/duplication testing until two pathogenic variants are identified. Clinical sensitivity is 99%.
- 0051640 Cystic Fibrosis (CFTR) Sequencing with Reflex to Deletion/Duplication** - CFTR gene sequencing; if two pathogenic variants are not identified, deletion/duplication testing is performed. Clinical 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

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