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 Name _____ Date of Birth_____ /_____/_____Sex [ ] 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
[ ] Bilateral absence of the vas deferens [ ] Chronic cough [ ] Fetal echogenic bowel [ ] Pneumonia
[ ] Azoospermia [ ] COPD [ ] Meconium ileus [ ] Pseudomonas
[ ] Bronchiectasis [ ] Failure to thrive [ ] Pancreatitis [ ] Other _____

**Has SWEAT CHLORIDE testing been performed?** [ ] No [ ] Yes [ ] Unknown
If yes, what was result? _____ [ ] normal (<30) [ ] borderline (30-60) [ ] elevated (>60) [ ] QNS [ ] 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 variant(s) _____

**Is the patient's REPRODUCTIVE PARTNER a CF carrier?** [ ] Unknown [ ] No [ ] Yes List the variant_____
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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