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

Master Label