ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

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

PATIENT HISTORY FOR CYSTIC FIBROSIS (CF) TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity (check all that apply)

☐ Black or 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)

☐ Azoospermia ☐ COPD ☐ Pancreatitis
☐ Bilateral absence of the vas deferens ☐ Failure to thrive ☐ Pneumonia
☐ Bronchiectasis ☐ Fetal echogenic bowel ☐ Positive newborn screen
☐ Chronic Cough ☐ Meconium ileus ☐ Pseudomonas
☐ 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?

Check the test you intend to order.

☐ **2013661 Cystic Fibrosis (*CFTR*) 165 Pathogenic Variants:** Recommended for carrier screening and as first line diagnostic test in symptomatic patients. Clinical sensitivity for carrier detection is 78% in African American/Black, 96% in Ashkenazi Jewish, 55% in Asian American, 92% in Caucasian, and 80% in Hispanic patients.

☐ **2013664 Cystic Fibrosis (*CFTR*) 165 Pathogenic Variants w/Reflex to Sequencing w/Reflex to Deletion/Duplication:** Test begins with 165 variants and reflexes 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 mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

☐ **3003144 Deletion/Duplication Analysis by MLPA:** Tests large *CFTR* deletion/duplication previously identified in a family member; copy of relative's lab report is REQUIRED.

Master Label

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