ARUP LABORATORIES

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

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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:** ☐ 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)

☐ 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?

Master Label

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