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Cystic Fibrosis Screening Questionnaire

This form should be filled out when DNA testing for cystic fibrosis mutations is ordered (tests 480533, 480541, 480555, 332859, or 333561). The form should be completed by the ordering physician's office and should accompany the sample. Please call 800-345-4363 with any questions.

Patient's name: _____

Date of birth: _____ Gender: _____ M _____ F

Name of person completing form: _____

Physician's signature: _____ Physician's telephone: _____
Physician signature is requires on printed from

Indications for Testing

_____ Routine carrier screening of patient _____ Fetal analysis of known carrier parents _____ CVS ____ amniotic fluid

_____ Screening for partner of a previously identified carrier _____ Suspected/known diagnosis of symptomatic individual

Mother's mutation _____ Father's mutation _____

_____ Other _____

Patient Ethnicity

_____ Ashkenazi Jewish _____ Asian _____ Caucasian/White _____ Native American/American Indian _____ Hispanic

_____ African American/Black _____ Unknown _____ Other (please specify) _____

Patient History

Is this patient/this patient's partner currently pregnant? _____ Yes _____ No

If so, what is the current gestational age? _____

Has anyone in the patient's family been diagnosed with cystic fibrosis? _____ Yes _____ No

If yes, what is his/her relationship to the patient (brother, sister, niece, first cousin, second cousin, etc)? _____

If known, please list the cystic fibrosis mutation(s). _____

Has anyone in the patient's family been identified as a carrier for a cystic fibrosis mutation? _____ Yes _____ No

If yes, what is his/her relationship to the patient (brother, sister, first cousin, second cousin, etc)? _____

If known, please list the cystic fibrosis mutation(s). _____

If this patient is suspected of having cystic fibrosis, what clinical symptoms/ultrasound findings are present?

_____

Has the individual been sweat tested? _____ Yes _____ No Was the sweat test positive? _____ Yes _____ No

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