ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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 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 _____ Physician Fax _____

Genetic Counselor _____ Counselor Phone _____

Patient's Ethnicity (check all that apply)

☐ African-American ☐ Asian ☐ Hispanic ☐ Native American
☐ Ashkenazi Jewish ☐ Caucasian ☐ Middle Eastern ☐ Other: _____

Is the patient pregnant? ☐ No ☐ Yes ☐ N/A

Did the patient have a positive newborn screen for CF? ☐ No ☐ Yes (describe): _____

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply)

☐ Azoospermia ☐ Chronic cough ☐ Fetal echogenic bowel ☐ Pneumonia
☐ Bilateral absence of the vas deferens ☐ COPD ☐ Meconium ileus ☐ Pseudomonas
☐ Bronchiectasis ☐ Failure to thrive ☐ Pancreatitis
☐ 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? ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

_____

Is there any relevant family history of CF? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relationship of the family member(s) to the patient: _____

Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown

If yes, indicate: The relative is: ☐ a healthy carrier ☐ affected List the variants: _____

Attach a copy of the relative's DNA laboratory result. (REQUIRED for familial mutation testing.)

Is the patient's reproductive partner a CF carrier? ☐ No ☐ Yes ☐ Unknown

If yes, list the variant: _____

Does the patient's reproductive partner have any relevant family history of CF? ☐ No ☐ Yes ☐ Unknown

If yes, specify the relationship of family member(s) to the partner: _____

Indicate: The relative is: ☐ a healthy carrier ☐ affected

Check the test 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 mutation previously identified in a family member; a copy of relative's lab result is REQUIRED.

Master Label

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