Cystic Fibrosis Screening Questionnaire

This form should be filled out when routine DNA screening for common cystic fibrosis is ordered (480533). 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 ____________________________________________

**Indications for Testing** (check box(es) that apply)

- □ Routine carrier screening
- □ Screening for partner of a previously identified carrier
- □ Routine screening of fetus (either on CVS or amniotic fluid)
- □ Suspected diagnosis of fetus/symptomatic individual
- □ Known diagnosis of symptomatic individual

**Patient History**

Is this patient/this patient’s partner currently pregnant? □ Yes □ No

If so, what is the gestational age? ____________________________

Has anyone in the patient’s family been diagnosed with cystic fibrosis or been identified as a carrier for a cystic fibrosis mutation? □ Yes □ No

If yes, what is their relationship to the patient (brother, sister, niece, etc)? ____________________________

If this patient is suspected to have cystic fibrosis, what clinical symptoms/ultrasound findings are present? ____________________________________________

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

**Patient Ethnicity**

- □ American Black
- □ Ashkenazi Jewish
- □ Asian
- □ Caucasian, Northern Europe (Poland, Germany, etc)
- □ Caucasian, Southern Europe (Italy, Greece, etc)
- □ Hispanic (Puerto Rican)
- □ Hispanic (Mexican)
- □ Hispanic (other) ____________________________
- □ Native American
- □ Other ____________________________
- □ Unknown Race/Ethnicity