CYSTIC FIBROSIS DNA TEST REQUISITION

For testing at the Molecular Diagnostics Laboratory of The Nebraska Medical Center

This form should accompany specimen or can be faxed directly to the laboratory at 559-5690.

PATIENT DATA:

Name (Last, First, Middle Initial):_____

Date of Birth (MM/DD/YY): _____/_____/_____ Hospital #:_____

Please check one: ☐ male ☐ female Pregnant? ☐ yes ☐ no

Date collected (MM/DD/YY): _____/_____/_____

Specimen Type: ☐ blood (5 ml EDTA tube)

ETHNIC BACKGROUND:

☐ European Caucasian ☐ Hispanic

☐ Ashkenazi Jewish ☐ African American

☐ Other Jewish ☐ Native American Indian

☐ Asian ☐ Other _____

INDICATION FOR TESTING:

☐ Symptomatic/Clinical Findings (summarize):

☐ General Population Carrier Screening

☐ Reproductive Partner is a Carrier of a CF Mutation

If yes, please list identified CF mutation _____

☐ Family History: Known Familial Mutation? □ yes □ no

If yes, what is the specific relationship of the family member(s) to this patient? _____

What is the identified CF mutation in the family member(s)? _____

Please attach report of the identified CF mutation that has been identified in the family. Positive control DNA may be required in some cases. In addition, please provide Family History/Pedigree on back of form. Identify the patient with an arrow.

☐ Other

REPORTING INFORMATION

Ordering Physician:_____
Address:_____
_____
City, State, Zip_____
Phone #: (____) _____ Fax #: (____) _____

Additional Reports to:

1. Name: _____
Fax #: _____
2. Name: _____
Fax #: _____