

Cystic Fibrosis Mutation Analysis Testing

PATIENT INFORMATION

**This Form must
accompany the
test requisition**

LAB USE ONLY

PLACE ACCESSION LABEL HERE

PHYSICIAN PLEASE COMPLETE:

Patient MRN (Medical Reference Number) _____

Patient First Name: _____ MI: _____

Patient Last Name: _____

Patient Birth Date: ____/____/____ Gender: Female Male

Physician: _____

**Personal
History:**

Positive Negative Assumed Negative

**Race/Ethnicity:
(Check all
that apply)**

Note: The following information is required for carrier testing only

Non-Hispanic Caucasian African American Not Provided
 Ashkenazi Jewish Hispanic American Unknown
 Asian American Complex Not Solicited

**Family
History:**

Note: The following information is required for carrier testing only

Is there a family history of this disease? Yes No Unknown

(Describe relationship of positive family member and familial mutation(s), if known :

This form may contain PRIVILEGED AND/OR CONFIDENTIAL INFORMATION

DO NOT copy or deliver this information to anyone else.

Please attach this form with requisition

CompuNet
CLINICAL LABORATORIES

6/09