



4531 West Harrison Street Hillside, IL 60162  
Tel: 708-488-1000 Fax: 708-488-1831

**CYSTIC FIBROSIS PATIENT HISTORY** (To be completed by ordering provider)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:    Male        Female

Client Acct: \_\_\_\_\_ Physician/Genetic Counselor: \_\_\_\_\_

Physician / Counselor Phone: \_\_\_\_\_

Comments or Special Instructions: \_\_\_\_\_

**Reason for Cystic Fibrosis Mutation Analysis** (Check only one):

Population screening or carrier testing (patient has no symptoms)

Suspect patient has CF disease or symptoms of classic CF

Patient has symptoms of non-classic CF (isolated pancreatitis, sinusitis, or CBAVD)

**Yes      No    Symptoms of Cystic Fibrosis**

If yes, please list: \_\_\_\_\_

**Yes      No    Family History of Cystic Fibrosis**

If yes, please answer the following questions:

1. Is the relative affected with symptoms of CF or is he / she a healthy carrier?

\_\_\_\_\_

2. Describe the relationship of the relative to the patient: \_\_\_\_\_

3. List the CF mutation(s) in the relative: \_\_\_\_\_

**Patient's Ethnicity** (please check one):

African American

Ashkenazi Jewish

Asian

Caucasian

Hispanic

Other: \_\_\_\_\_

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**For Lab Use Only**

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Lab Accession Number: \_\_\_\_\_

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