



CYSTIC FIBROSIS INFORMATION RELEASE FORM

PATIENT INFORMATION: MUST BE TYPED OR PRINTED

Patient Last Name _____ First Name _____ MI _____

Patient SS# _____ - _____ - _____ Patient DOB _____ Patient Sex _____

REFERRING PHYSICIAN NAME: _____ PHONE: _____ FAX _____

CYSTIC FIBROSIS TESTS (CHECK ONLY ONE)

Cystic Fibrosis Mutation Panel (0056040) Tests for the 32 most common mutations in the CF gene, including F508
 Order based on the following indication:

1. Patient possibly affected with CF
2. Population screening/Carrier testing
3. Family history of CF; Unknown mutations or at least one mutation that is not F508

Cystic Fibrosis F508 Del Only (0056005); Tests for the presence of F508 (one mutation in the CF gene). Order when there is documented family history of only the F508 mutation.

Cystic Fibrosis – Congenital Bilateral or the Vas Deferens (0097337); Tests for the 32 most common CF gene mutations and I VS-8 5T. Order for men with confirmed congenital absence of the vas deferens and in case of atypical CF.

REASON FOR CF DNA ANALYSIS (CHECK ONLY ONE)

Suspect patient may be affected

Population screening/Carrier Testing

Infertile male with CBAVD and atypical CF

DOES THIS PATIENT HAVE ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

| | | | |
|----------------------------------|-----|----|--------------------------|
| Family history of CF | Yes | No | Specific Mutations _____ |
| Positive sweat chloride test | Yes | No | Borderline Not Done |
| Bowel obstruction | Yes | No | |
| Failure to thrive | Yes | No | |
| Recurrent pneumonia/Lung Disease | Yes | No | |

WHAT IS THE PATIENT'S ETHNICITY (CHECK ALL THAT APPLY)

| | | |
|------------------|----------|-------------------|
| African American | Asian | Ashkenzazi Jewish |
| Caucasian | Hispanic | Multiethnic |
| Other _____ | | |

I authorize Physician's Preferred Laboratory to submit this information with my laboratory samples as required by the reference laboratory in order to perform the necessary testing on my behalf. I authorize a copy of this authorization to be used in place of the original. I authorize PPL to release records for the purpose of obtaining medical treatment and a copy of this form may be used in lieu of the original. I hereby authorize PPL to administer/perform that which has been prescribed by my physician.\

Signature

Date