



# Cystic Fibrosis Patient Profile

FAX FORM TO MOLECULAR DIAGNOSTICS 509-474-6876



\_\_\_\_\_  
PATIENT'S NAME (FIRST, MI, LAST)

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
PHYSICIAN'S NAME (FIRST, LAST)

**ETHNIC BACKGROUND**

*(Check all that apply)*

- Caucasian                       Hispanic                       Native American
- Ashkenazic Jewish             African American     Asian
- Other Jewish / PLEASE SPECIFY: \_\_\_\_\_
- Other / PLEASE SPECIFY: \_\_\_\_\_

CLINICAL INDICATION: \_\_\_\_\_

**CARRIER SCREEN**

POSSIBLE CYSTIC FIBROSIS DIAGNOSIS SYMPTOMS: \_\_\_\_\_

FAMILY HISTORY OF CYSTIC FIBROSIS?	YES	NO
IF YES, IS THE RELATIVE:	AFFECTED	CARRIER

IF KNOWN, PLEASE SPECIFY RELATIVE: \_\_\_\_\_

IF KNOWN, PLEASE SPECIFY MUTATION(S): \_\_\_\_\_

If you have any questions, please call PAML Client Services at 1-800-541-7891, Option 1



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