



Cystic Fibrosis Patient Profile

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

Date Drawn:

Time Drawn:

THIS IS NOT A TEST REQUEST FORM
The information below is required to perform cystic fibrosis testing.
Please fill out this form and submit it with the test request form or electronic packing list.

Social Security #	Accession #	
Patients Name (First, Mi, Last)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Physicians Name (First, Last)	Phone Number	Fax Number

Ethnic Background

<input type="checkbox"/> Caucasian-Non Hispanic	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native American
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> African American	<input type="checkbox"/> Asian
<input type="checkbox"/> Other Jewish / PLEASE SPECIFY: _____	<input type="checkbox"/> Other / PLEASE SPECIFY: _____	

Clinical Indication

<input type="checkbox"/> Carrier screen due to pregnancy
<input type="checkbox"/> Carrier screen, other specify _____
<input type="checkbox"/> Diagnostic study
List all relevant clinical symptoms:

Family History: Please provide information on patient and reproductive partner if this is a carrier screening due to a current or planned pregnancy.

Patient	Any relatives known to be affected with CF? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate relationship to the patient:	Reproductive partner	Any relatives known to be affected with CF? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate relationship to the partner:
	Any relatives known to be a CF carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate relationship to the patient:		Any relatives known to be a CF carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate relationship to the partner:

Mutations

IF KNOWN, PLEASE SPECIFY MUTATION(S) in affected or carrier relatives:
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