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 (CIRCLE 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 (CIRCLE 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 (CIRCLE 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 (CIRCLE 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

3501 SONCY STE. 116 • AMARILLO TX 79119

OFFICE (806) 358-1211 • FAX (806) 358-3477 • WWW.LABPPL.COM