HealthLab
25 North Winfield Road
Winfield, Illinois 60190
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HEALTHLAB

Cystic Fibrosis Carrier Clinical Information

Test code: 2843 2-4 mL EDTA (lavender) tubes Ambient temperature

Patient name: _____

Date of birth: _____ Social Security: _____

Patient sex (please circle): Male Female

- Reason for ordering test _____
- Ethnic/racial background _____
- Is there a history of this condition in the patient's family? ___ Yes ___ No ___ Unknown
- Has the patient or a family member had this test before? ___ Yes ___ No ___ Unknown

If yes, please indicate:

Relationship to the patient	Affected	Carrier	Test result(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please complete all information and attach this form to the test requisition.
Send both with the specimen in the transport bag to the laboratory.