

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.