

Patient Information Request for Cystic Fibrosis (CF) Testing

In order to assist us to provide you and your patient with a prompt and appropriate report, we require the following information before we can proceed:

***** PLEASE COMPLETE ALL SECTIONS *****

Patient's name DOB Hospital No.

A Reason for Referral

Please Circle

- (1) Your patient has **symptoms** suggestive of CF, and you would therefore like to determine whether they are **affected** with CF Y N
- (2) Your patient has a **definite clinical diagnosis of CF**, but has never had genetic testing, and would like to determine their genotype Y N
- (3) CF testing required as your patient and/or their partner is awaiting/undergoing **assisted reproduction** Y N
- (4) Your patient does not have symptoms of CF but **has a family history of CF**, and would like to determine their carrier status. Y N

Please fill in your patient's family history details overleaf

**Please note that the recommended minimum age for carrier testing is 16 years in accordance with internationally recognised guidelines*

- (5) Your patient **has a partner** ;
- a) who has been **diagnosed** with CF Y N
- b) who is a **carrier** of a CF mutation Y N
- c) who has a **family history of CF**
(NB: Fill in details overleaf) Y N
- and your patient would like to know their own carrier status in order to determine their risk of having a child with CF.
- Partner's details:**
- | Name | Date of Birth | Genetic results (or where tested) |
|----------------------|----------------------|-----------------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

B Clinical Details of your Patient

Sweat test Levels (Cl⁻, Na⁺ and/or combined):

Centre where tested:

Clinical symptoms of CF/CBAVD present:

Tick this box if carrier status required and clinical details are NOT APPLICABLE TO YOUR PATIENT

Important note: The complete history of this document including its owner, author and revision date can be found on Q-Pulse

CONTROLLED DOCUMENT

Document Number: DOC455

Revision Number: 3

Page 1 of 2

Authorised by: MGM

C Family History Information

If your patient has **NO KNOWN family History of CF**, please Tick

If your patient and/or their partner **HAS a family history of CF**, fill in below.

Your patient	Your patient's partner
<i>(For choice 5 (c) overleaf)</i>	
<i>Name of <u>affected/carrier</u> family member(s) (please specify whether affected <u>or</u> carrier)</i>	
<input type="text"/>	<input type="text"/>
<i>Date of birth of affected/carrier family member(s)</i>	
<input type="text"/>	<input type="text"/>
<i>Relationship of affected/carrier family member(s) to your patient/patient's partner</i>	
<input type="text"/>	<input type="text"/>
<i>Genetic results of affected/carrier family member(s) or where tested (if known)</i>	
<input type="text"/>	<input type="text"/>

D Ethnicity

Is (are) your patient (and partner) of **Irish Origin?**

(Our test covers the 92.5% of the mutations found in the Irish population, coverage may be reduced or unknown for individuals of another ethnic origin)

Patient Y N

Partner Y N

If **NO**, please give details of **ethnic origin**

Patient

Partner

Please feel free to provide any other information that you think may be relevant

E Name and contact number of person completing this questionnaire *Please print clearly*

PLEASE RETURN TO: Duty Scientist, National Centre for Medical Genetics, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12 or Fax (01) 4096971

This form can also be downloaded at www.genetics.ie

Important note: The complete history of this document including its owner, author and revision date can be found on Q-Pulse

CONTROLLED DOCUMENT

Document Number: DOC455

Revision Number: 3

Page 2 of 2

Authorised by: MGM