

## 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 <b>symptoms</b> suggestive of CF, and you would therefore like to determine whether they are <b>affected</b> with CF       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (2) Your patient has a <b>definite clinical diagnosis of CF</b> , but has never had genetic testing, and would like to determine their genotype | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (3) CF testing required as your patient and/or their partner is awaiting/undergoing <b>assisted reproduction</b>                                | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (4) Your patient does not have symptoms of CF but <b>has a family history of CF</b> , and would like to determine their carrier status.         | <input type="checkbox"/> Y <input type="checkbox"/> 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 <b>has a partner</b> ;  |   |
| a) who has been <b>diagnosed</b> with CF   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| b) who is a <b>carrier</b> of a CF mutation  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c) who has a <b>family history of CF</b><br>(NB: Fill in details overleaf)   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| and your patient would like to know their own carrier status in order to determine their risk of having a child with CF. |   |
| <b>Partner's details:</b>  |   |
| <i>Name</i>  | <i>Date of Birth</i>                                  |
| <input style="width: 150px;" type="text"/>   | <input style="width: 100px;" type="text"/>            |
| <i>Genetic results (or where tested)</i>   |   |
| <input style="width: 350px;" type="text"/>   |   |

### B Clinical Details of your Patient

Sweat test Levels (Cl <sup>-</sup> , Na <sup>+</sup> 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	
<input style="width: 50px; height: 20px;" type="checkbox"/>	

## 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>	
<i>Date of birth of affected/carrier family member(s)</i>	
<i>Relationship of affected/carrier family member(s) to your patient/patient's partner</i>	
<i>Genetic results of affected/carrier family member(s) or where tested (if known)</i>	

## 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](http://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**

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