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CFTR Patient Information Form

Providing the following clinical information is critically important in helping us to interpret genotype variations and to provide optimal genotype analysis on your patient:

1. General Information:

Name of Patient <i>First:</i> _____ <i>Last:</i> _____	Ethnic origin: Asian <input type="checkbox"/> Black or African <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/>
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Pregnancy: No Yes If yes, Due date _____ month _____ date _____ year

2. Test ordered:

- Full Sequencing
- Known Mutation Detection: (indicate mutation and proband’s identifier): _____

3. Indication for testing (check all that apply):

- Diagnosis of CFTR-related disorder
- Patient is a possible carrier due to a relative with known mutation(s)
- Patient had a positive sweat test
- Patient had a borderline sweat test
- Positive newborn screening

4. Patient Diagnosis (or diagnosis of affected relative, if patient being tested is not affected; indicate relation: _____)

- Cystic Fibrosis
- CBAVD (Congenital Bilateral Absence of the Vas Deferens)
- Chronic Pancreatitis
- Bronchiectasis
- Congestion
- Other (please indicate): _____

5. Patient is:

- Pancreatic sufficient
- Pancreatic insufficient

6. Please sketch or attach pedigree