THIS FORM SHOULD BE COMPLETED BY THE PRESCRIBING PHYSICIAN AND SENT WITH THE BLOOD SAMPLE

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Clinical Information Form
Cystic fibrosis gene analysis
(CFTR gene)

CONTACT DETAILS • Tel.: **+353 (0)1 295 8545** • Fax: **+353 (0)1 295 8550** • E-mail: **sales@eurofins-biomnis.ie**

PATIENT DETAILS

Surname: .....

First name: .....

Date of birth: ☐☐/☐☐/☐☐☐☐

Gender: ☐ F ☐ M

PRESCRIBING PHYSICIAN

Surname: Dr .....

Address: .....

Post code: ☐☐☐☐☐☐ Town: .....

Tel.: ☐☐☐☐☐☐☐☐☐☐

FAMILY TREE

Geographical origin*: .....
*(*the frequency and distribution of the mutations vary depending on the ethnic/geographical origin of the patient)*

Consanguinity: ☐ YES *(please indicate on the tree)* ☐ NO

ACKNOWLEDGEMENT OF CONSULTATION

I confirm that I have obtained informed consent from:

.....

.....

Signed in *(town)* .....

on ☐☐/☐☐/☐☐☐☐

Physician's signature

REASON BEHIND THE TEST REQUEST FOR A CHILD OR ADULT

☐ **Suspected cystic fibrosis**

☐ ENT disease: .....

☐ Respiratory disease: .....

☐ Digestive system disease: .....

☐ Pancreatic affection: .....

Sweat test: ☐ NO ☐ YES, result *(please indicate the units+ reference range):* .....

☐ **Infertility**

Bilateral absence of the vas deferens: ☐ NO ☐ YES

Please include the ultrasound scan and test results

☐ **Medically assisted procreation**

☐ **Ovum donation**

☐ **Suspected cystic fibrosis in a fœtus**

LMP: ☐☐/☐☐/☐☐☐☐ Date of conception: ☐☐/☐☐/☐☐☐☐

Amniocentesis: ☐ NO ☐ YES

Digestive enzyme assay on amniotic fluid: ☐ NO ☐ YES, results: .....

Please include the ultrasound scan(s) and test results

☐ **Family investigation**

☐ Heterozygote screening of the family of a patient with cystic fibrosis

Familial mutation to be screened for: .....

Please include the CFTR gene analysis test results

☐ Heterozygote screening for ☐ a partner of an afflicted individual ☐ a partner of heterozygous individual

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