NorthShore
University HealthSystem

Laboratory Services
9811 Woods Drive, Suite H180
Skokie, IL 60077
www.northshore.org
Phone (847) 663-2100
Fax (847) 663-2101

CYSTIC FIBROSIS FORM

PATIENT NAME: _____ DOB: _____

DOCTOR NAME: _____ COLLECTION DATE: _____

TELEPHONE: _____ FAX: _____

PLEASE CIRCLE

PREGNANT**:** NO YES WEEKS: _____ DAYS: _____

CARRIER SCREENING

NO FAMILY HISTORY: _____

FAMILY HISTORY RELATION: _____

_____

RELEVANT INFORMATION: _____

_____

SUSPECTED DIAGNOSIS

FAMILY HISTORY RELATION: _____

_____

RELEVANT INFORMATION: _____

_____

ETHNICITY (CIRCLE ONE)

ETHNIC BACKGROUND IS NEEDED FOR COMPLETE CYSTIC FIBROSIS RISK ASSESSMENT

HISPANIC AMERICAN ASHKENAZI JEWISH

CAUCASIAN

ASIAN

AFRICAN AMERICAN OTHER: _____