



**EVANSTON
NORTHWESTERN
HEALTHCARE**

REFERRAL Lab
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CYSTIC FIBROSIS FORM

PATIENT NAME _____ **DATE OF BIRTH** _____

DOCTOR NAME _____ **COLLECTION DATE** _____

PHONE _____ **FAX** _____

PLEASE CIRCLE ALL THAT APPLY

PREGNANT? NO YES WEEKS _____ DAYS _____
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<p>CARRIER SCREENING?</p> <p>NO FAMILY HISTORY</p> <p>FAMILY HISTORY RELATION:</p> <p>_____</p> <p>RELEVANT INFORMATION:</p> <p>_____</p> <p>_____</p>
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<p>SUSPECTED DIAGNOSIS?</p> <p>FAMILY HISTORY RELATION:</p> <p>_____</p> <p>RELEVANT INFORMATION:</p> <p>_____</p> <p>_____</p> <p>_____</p>

***** ETHNIC BACKGROUND IS NEEDED FOR COMPLETE CYSTIC FIBROSIS RISK ASSESSMENT*****

<p>ETHNICITY? (CIRCLE ONE)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;"> <p>N. EUROPEAN CAUCASIAN <i>(UK, IRELAND, POLAND, SCANDINAVIAN)</i></p> </td> <td style="width: 50%; padding: 5px;"> <p>ASKENAZI JEWISH</p> </td> </tr> <tr> <td style="padding: 5px;"> <p>S. EUROPEAN CAUCASIAN <i>(GREECE, SPAIN, ITALY, MEDITERRANEAN)</i></p> </td> <td style="padding: 5px;"> <p>SEPHARDIC JEWISH</p> </td> </tr> <tr> <td style="padding: 5px;"> <p>ASIAN</p> </td> <td style="padding: 5px;"> <p>NATIVE AMERICAN</p> </td> </tr> <tr> <td style="padding: 5px;"> <p>AFRICAN AMERICAN</p> </td> <td style="padding: 5px;"> <p>OTHER _____</p> </td> </tr> </table>		<p>N. EUROPEAN CAUCASIAN <i>(UK, IRELAND, POLAND, SCANDINAVIAN)</i></p>	<p>ASKENAZI JEWISH</p>	<p>S. EUROPEAN CAUCASIAN <i>(GREECE, SPAIN, ITALY, MEDITERRANEAN)</i></p>	<p>SEPHARDIC JEWISH</p>	<p>ASIAN</p>	<p>NATIVE AMERICAN</p>	<p>AFRICAN AMERICAN</p>	<p>OTHER _____</p>
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