REFERRAL Lab
2650 Ridge Ave.
Evanston, IL 60201
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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**_____

CARRIER SCREENING?

NO FAMILY HISTORY

FAMILY HISTORY RELATION:

_____

RELEVANT INFORMATION:

_____

_____

SUSPECTED DIAGNOSIS?

FAMILY HISTORY RELATION:

_____

RELEVANT INFORMATION:

_____

_____

_____

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

ETHNICITY? (CIRCLE ONE)

N. EUROPEAN CAUCASIAN
(UK, IRELAND, POLAND, SCANDINAVIAN)

ASKENAZI JEWISH

S. EUROPEAN CAUCASIAN
(GREECE, SPAIN, ITALY, MEDITERRANEAN)

SEPHARDIC JEWISH

ASIAN

NATIVE AMERICAN

AFRICAN AMERICAN

OTHER_____