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Organization Name: _____

Organization Address: _____

City: _____ ST: _____ Zip _____

Phone: _____ Fax: _____

Ordering Provider: _____

Consulting Provider: _____

All information required for valid order

SPECTRUM HEALTH

REQUISITION
CYSTIC FIBROSIS (CF) TEST

*DATE ORDERED	DATE COLLECTED	TIME COLLECTED	INITIALS COLLECTED

*ORDER EXPIRATION

☐ 30 Days ☐ 60 Days ☐ 180 Days ☐ 365 Days

Note: No indication of order expiration date will default to 180 days

Standing Orders: ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other: _____

*PATIENT INFORMATION

NAME LAST FIRST MIDDLE INT.

ADDRESS PHONE

CITY STATE ZIP

SEX	MARITAL STATUS	BIRTH DATE	CELL PHONE

*DIAGNOSIS/ICD-9 CODES

1st _____

2nd _____

Other _____

Other _____

INSURANCE INFORMATION

Providers submitting SPECIMEN orders please attach copy(s) of Insurance cards (front and back). Please indicate Primary and Secondary.

CMS requires a provider signature on all laboratory requisition orders. Initialing the line in front of your name shall serve as your authorized signature.

Provider Signature_____

Additional report to: Provider _____ Fax_____

Order Comment _____

CF ANALYSIS REQUESTED FOR

- ☐ CF confirmation
- ☐ CF carrier screen
- ☐ Infertile male with CBAVD
- ☐ Unsatisfactory sweat chloride test
- ☐ Infant with meconium ileus
- ☐ Echogenic bowel in fetus
- ☐ Prenatal testing (at risk pregnancies only, for couples having a CF mutation in both partners

☐ **Provider counseled and obtained consent before ordering**

ETHNICITY: MUST BE COMPLETED FOR FULL INTERPRETATION

- ☐ African American
- ☐ Asian
- ☐ Askenazi Jewish
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American Indian
- ☐ Multiethnic_____
- ☐ Other_____

Positive Family History of CF	☐ Yes	☐ No	If yes, list the specific mutation(s)_____
Partner with positive family history	☐ Yes	☐ No	
Partners of CBAVD male	☐ Yes	☐ No	
Positive Sweat Chloride Test	☐ Yes	☐ No	☐ Pos ☐ Borderline ☐ Not done
Male infertility (CBAVD)	☐ Yes	☐ No	
Other	☐ Yes	☐ No	Explain _____

42 CFTR MUTATIONS. The mutations in bold are revised (204) 23 mutations recommended by ACOG/ACMG

1078delT	3120+1G > A	394delTT	**DF508**	I148T	R347H	S549R T > G
1717-1G > A	**3659delC**	**621+1G > T**	**DI507**	**N1303K**	**R347P**	V520F
1898+1G > A	**3849+10kbC > T**	**711+1G > T**	E60X	Q493X	**R553X**	**W1282X**
2183AA > G	3849+4A > G	**A455E**	**G542X**	**R1162X**	**R560T**	Y1092X C > A
2184delA	3876delA	D1152H	**G551D**	**R117H**	S549N	Y1092X C > G
2789+5G > A	3905insT	D1270N	**G85E**	**R334W**	S549R A > C	Y122X

White - Laboratory Yellow - Physician's Office

NOTE: FOR MEDICARE PATIENTS, PLEASE ATTACH COMPLETED ABN FORM CMS-R 131 AS NEEDED

MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS, CERTAIN EXCEPTIONS MAY APPLY

*INDICATES INFORMATION REQUIRED FROM OFFICE FOR VALID WRITTEN ORDER

SPECTRUM HEALTH LABORATORY SERVICES 616-774-7721

LAB450 12/10