

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- 4 ml blood in EDTA tube(s)
- Bloodspot filter paper

PATIENT: _____
last first

BIRTH DATE: ____ / ____ / ____ SSN #: ____ - ____ - ____
mm dd year

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ - _____ GENDER: Female Male

RACE: White Black Asian American Indian / Alaskan Native
 Native Hawaiian / Pacific Islander Unknown

ETHNICITY: Hispanic Non Hispanic Unknown

PATIENT ID #: _____

CLINICIAN: _____ CLINICIAN ID #: _____
please print last first

PHONE: (____) _____ - _____ CLINICIAN'S Signature: _____

DATE COLLECTED: ____ / ____ / ____
mm dd year

Required Information

Note: Information essential for accurate risk assessment
 IOWA Cystic Fibrosis Carrier Screening requires a specimen and completed request form
 from BOTH male and female reproductive partners.

The ONLY exception is for Screening requested for the parents of an infant identified as a carrier of CF by Iowa Newborn Screening.
 Samples not meeting these requirements will be rejected.

Is there a family history of cystic fibrosis?

- NO family history of cystic fibrosis **(complete section A)**
- Yes -- family history of an individual who is affected with cystic fibrosis (see below)
- Yes -- family history of an individual who is a carrier of cystic fibrosis (see below)

If YES, is this individual related by blood to a child who was identified by Iowa Newborn Screening as being affected with or a carrier of cystic fibrosis?

- Yes, son / daughter was identified by Iowa Newborn Screening **(complete sections A and C)**
- Yes, other relative was identified by Iowa Newborn Screening **(complete sections A, B, and C)**
- No **(complete sections A and B)**

Section A

Test Specific Ethnic Group of Patient

Please check one:

- Caucasian (non-Hispanic)
- Ashkenazi Jewish
- Hispanic American
- African American
- Asian American
- None of the above

Section B

Family History

What is the relationship of the affected or carrier individual to this patient being tested? (please check one)

- Sibling
- Niece / Nephew
- Aunt / Uncle
- 1st Cousin
- More distant relative
please specify: _____
- Self

Section C

Child identified by Iowa Newborn Screening

Name of child: _____

Date of Birth: ____ / ____ / ____
mm dd year

Lab # (if known): _____

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____
please print

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____



Enter your facility address
 Results are returned
 to this address

**IOWA Cystic Fibrosis
 Carrier Screen
 Test Request Form**

University Hygienic Laboratory
 Iowa Laboratories Complex
 2220 S. Ankeny Blvd, Ankeny, IA 50021
 Phone #: 515-725-1600
 Fax #: 515-725-1642
<http://www.uhi.uiowa.edu>