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Clinical Questionnaire for **Cystic Fibrosis (CF) Screening**

Please include this form with sample and order for testing.

Patient Information

First Name:_____ **Last Name:**_____ **Date of Birth:**_____

The submission of this form is not an order for a test. LabCorp may use information obtained on this form and other information provided by the patient and/or ordering provider or his/her designee to initiate preauthorization with the patient's health plan as required. Pretest counseling has occurred with the patient in accordance with their health plan requirements if applicable. The patient understands a preauthorization approval from their health plan does not guarantee full payment.

Patient _____ **Date** _____ **/ Physician** _____ **Date** _____

Testing Information (to be completed by the provider)

	Test #	CPT		Test #	CPT
❍ Cystic Fibrosis (CF) Profile, 97 Mutations, CF*plus*®	450020	81220	❍ Cystic Fibrosis (CF) Profile, 97 Mutations, CF*plus*®, Fetal Analysis	480819	81220
❍ Cystic Fibrosis (CF) Profile, 32 Mutations, DNA Analysis	480533	81220	❍ Cystic Fibrosis (CF) Profile, 32 Mutations, Fetal Analysis	480541	81220
❍ Cystic Fibrosis (CF): CFTR (Known Mutation)	252760	81221	❍ Cystic Fibrosis (CF): CFTR Prenatal Test (Known Mutation)	252885	81221
❍ Cystic Fibrosis (CF) Profile, DNA Analysis and 5T Allele Genotyping	480555	81220	❍ Cystic Fibrosis (CF): CFTR (Full Gene Sequencing) With Reflex to Deletion/Duplication Analysis	253095	81223
❍ Cystic Fibrosis (CF): CFTR (Full Gene Sequencing)	252763	81223	❍ CFTR Deletion/Duplication Analysis	252900	81222

Indication for Testing and Relevant Patient/Partner History (to be completed by the provider)

Patient Ethnicity: ❍ Ashkenazi Jewish ❍ Caucasian ❍ Native American ❍ Black ❍ Hispanic ❍ Other (specify) _____

❍ **Carrier screening. Mark all that apply.**
- ❍ Has patient had previous carrier screening? ❍ Yes ❍ No If yes, are screening results available? ❍ Yes ❍ No
- ❍ No known or suspected family history of CF
- ❍ Partner of a known mutation carrier (If marked, specify mutation): _____
- ❍ Partner has a diagnosis of CF
- ❍ Partner has known diagnosis of congenital absence of the vas deferens
- ❍ Biological relative has diagnosis of CF. If marked, specify relationship of individual to the patient (e.g. brother, sister, niece , first cousin, second cousin, etc): _____
- ❍ Biological relative is known mutation carrier. If marked, specify:
  - ❍ Relationship of individual to the patient (e.g. brother, sister, niece , first cousin, second cousin, etc): _____
  - ❍ Mutation or enter as unknown: _____
  - Are CF testing results available? ❍ Yes ❍ No
- ❍ Patient/partner is currently pregnant or is considering a pregnancy. If pregnant, specify gestational age: _____ weeks _____ days

❍ **Fetal testing (CVS or amniotic fluid [circle one]). Mark all that apply.**
- ❍ Mother is a known mutation carrier (specify mutation): _____
- ❍ Father is a known mutation carrier (specify mutation): _____
- ❍ Father has not had carrier testing
- ❍ Abnormal ultrasound findings (specify findings): _____
- ❍ Other indication (specify): _____

❍ **Suspect/confirm a CF diagnosis in an individual (child or adult). Mark all that apply.**
- ❍ Patient has been diagnosed with congenital absence of the vas deferens
- ❍ Patient has had a sweat test. If marked, was the sweat test positive? ❍ Yes ❍ No
- ❍ Patient has classic symptoms of CF (specify): _____
- ❍ Patient has atypical symptoms of CF (specify): _____

Laboratory/Facility Information

LabCorp / 1912 TW Alexander Drive; RTP, NC 27709 or PO Box 2240; Burlington, NC 27216	TIN #: **13-3757370**	NPI: **1750368700**
Esoterix Genetic Laboratories / 3400 Computer Drive; Westborough, MA 01581	TIN #: **27-3267315**	NPI: **1689975021**
Telephone Number: **877-998-7837**	Fax Number: **888-598-7568**	
Place of Service: **Independent Clinical Laboratory**	Email: **Preverification@LabCorp.com**	

Integrated GENETICS
LabCorp Specialty Testing Group

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