Indiana University Health

IU Health System Pathology Laboratories
350 W. 11th Street, Room 5013
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740
Fax: 317.491.6001

1) Patient Legal Name (Last, First MI)	DOB	2) ( ) STAT	Date/Time of Collection
Patient Social Security # / Race / MR#/Alternate Pt ID			Phone Results To:
Patient Address / Phone			Fax Results To:
City, State, Zip	M F	4) **BILL PATIENT/INSURANCE COMPANY**	
3) Physicians Signature / Order Date / Print Physicians Name (F,MI,L)		ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (highlighted) fields must be complete to bill patient's insurance company. Specimen will be registered as patient self-pay and bill will be the responsibility of the patient if required information is not provided.	

Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Insurance Co. Address:
Send Additional Report To:		City: State/Zip:
		Policy Holder Name:
		Relationship to Patient:

Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. If a test is being ordered as a screen, be certain the patient has signed the Advanced Beneficiary Notice (ABN) located on back of this requisition.

5) ICD Diagnosis Codes (Enter ALL that apply)		1	2	3
4	5	6	7	8

Genetic Counselor: Phone: Fax:

Cystic Fibrosis Mutation Analysis

☐ **CF 139 Mutation Analysis**

Please check appropriate box:

- ☐ Clinically normal individual with no family history of the condition
- ☐ Family history of the condition
- ☐ Spouse has family history of the condition
- ☐ Spouse is a carrier of the condition
- ☐ Anonymous egg or sperm donor

Specimen Type:

- ☐ Blood

☐ Diagnosis or suspected diagnosis (*List all relevant clinical symptoms*):

Ethnic Background—*Especially important to provide appropriate interpretation of CF test results. Please check appropriate box:*

- ☐ Northern European Caucasian
- ☐ Mixed European Caucasian
- ☐ Southern European Caucasian
- ☐ Caucasian - indicate countries of origin _____
- ☐ Other (specify) _____
- ☐ Hispanic
- ☐ Asian
- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ French Canadian

Pregnancy Information:
Is the patient or partner currently pregnant? ☐ Yes ☐ No If yes, how many weeks' gestation? _____

Family History:

Are other relatives known to be affected? ☐ Yes ☐ No If yes, indicate their relationship to patient: _____
Are other relatives known to be a carrier? ☐ Yes ☐ No If yes, indicate their relationship to patient: _____
Have other relatives had genetic testing? ☐ Yes ☐ No If yes, indicate the results (specific mutations) identified and the laboratory at which the testing was performed:

If the relative was tested previously, include the name of the family member:

Sample Collection Instructions:
Collect one Lavender EDTA tube (minimum volume 1.0 ml) and send to IUHPL refrigerated.
Complete ALL information on this form and send with specimen.

ATTENTION IUHPL Specimen Processing –
forward copy of paperwork/requisitions for all Cystic Fibrosis (CF) Mutation Analysis to Molecular

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City, State, Zip		M F	4) **BILL FACILITY / CLIENT**	
3) Physicians Signature	Order Date	Print Physicians Name (F, MI, L)	( ) Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid) **Attention PFN**: do not register, send patient directly back to lab	
Client (Clinic/Physician) Information			Group Physicians	
Send Additional Report To:				

Genetic Counselor:	Phone:	Fax:

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