TriCore Reference Laboratories (505) 938-8888 (505) 245-3296

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

FORM# 0000-16000

GCL CFMUT - GREEN

PATIENT INFORMATION (YELLOW AREAS MUST BE FILLED IN)

PATIENT LAST NAME	FIRST NAME	MI	PATIENT ID	DATE OF BIRTH	SEX	FASTING
					M F	YES NO

MAILING ADDRESS				ORDERING PHYSICIAN (FULL NAME	COMMENTS OR ADDITIONAL COPY OF REPORT T
CITY	STATE	ZIP	PATIENT PHONE		

SOCIAL SECURITY # PATIENT ONLY	DATE COLLECTED	TIME COLLECTED AM PM	COLLECTED BY
___ ___			

WHEN MEDICARE PAYMENT WILL BE SOUGHT, ONLY TESTS WHICH ARE MEDICALLY NECESSARY SHOULD BE ORDERED.

BILL TO

☐ PHYSICIAN/PROVIDER ☐ PATIENT RESPONSIBLE PARTY (ONLY IF PATIENT IS A MINOR)

SEE ATTACHED COPY OF CARD

☐ MEDICARE ☐ MEDICAID

SOCIAL SECURITY NUMBER ON INSURANCE CARD AND/OR MEMBER # (LETTER)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ ___

☐ PHP ☐ BCBS ☐ SALUD ☐ OTHER _____

INSURANCE ADDRESS: _____

PLAN NAME: _____ MEMBER ID NUMBER: _____

GROUP NUMBER: _____ EMPLOYER OF PRIMARY CARDHOLDER: _____

PRIORITY ☐ **STAT** ☐ **ASAP** ☐ **CALL** (OFFICE HRS ONLY) PHONE #_____ FAX TO #:_____

CFMUT - CYSTIC FIBROSIS MUTATION

☐ Signed Genetic Consent was obtained.

New Mexico state law requires informed consent for genetic analysis. This consent should be obtained by the ordering physician or genetic counselor before obtaining blood or other material. The original consent should be kept with the patient chart. Consent form can be printed from www.TriCore.org.

Specimen Submitted:

☐ Blood (1 EDTA or Blue citrate or ACD, whole blood) ☐ Amniotic fluid ☐ Chorionic villi ☐ Other _____

Ethnicity:

☐ Caucasian (Non-Hispanic) ☐ African - American ☐ Asian - American ☐ Other _____

☐ Hispanic ☐ Ashkenazi Jewish ☐ Native American - Please include tribal affliation _____

Indication:

1. CARRIER TESTING IN AN ASYMPTOMATIC INDIVIDUA
   - ☐ No family history of CF
   - ☐ Family history of CF(see below)
   - ☐ Partner of known CF carrier
   - ☐ Partner of infertile male
   - ☐ Gamete donor

2. DIAGNOSTIC TESTING
   - ☐ Known affected
     - Diagnosis confirmed by: ☐ Positive sweat test ☐ Other _____
   - ☐ Suspected diagnosis of CF
     - Symptoms: _____
   - ☐ Male infertility
     - ☐ Congenital absence of the vas deferens (CAVD)
     - ☐ Azoospermia
     - ☐ Oligospermia

3. FETAL TESTING
   - ☐ Family history of CF (see below)
   - ☐ Abnormal fetal ultrasound
     - Findings: _____

4. OTHER
   - ☐ _____

Family History of CF: ☐ Yes ☐ No

Relationship to this individual: _____ Pedigree (if available) _____

Mutation(s) Identified: _____

TRICORE REFERENCE LABORATORIES

Informed Consent for Genetic Analysis

LAST NAME: _____ FIRST NAME: _____

DOB: _____ GENDER: ❑ M ❑ F

I request genetic analysis for the purpose of:

❑ Cytogenetic analysis for constitutional abnormalities
❑ Hemochromatosis mutation detection
❑ Cystic Fibrosis
❑ Other

I request and authorize the physician identified below and/or TriCore Reference Laboratories to collect, obtain, retain, transmit, and use genetic information and samples for genetic analysis from (check one):

❑ me ❑ my minor child ❑ my fetus ❑ _____

for the purpose listed above. My signature below constitutes my acknowledgement that the principles, benefits, and risks of genetic analysis have been explained to my satisfaction by the physician listed below or by a genetic counselor. I acknowledge that I have had the opportunity to ask questions concerning the genetic analysis that is to be performed and the use of the test results and that my questions have been answered to my satisfaction.

I understand the following about the test procedure and its outcome:

1. Genetic analysis may:
   a) Diagnose whether I am or am not affected with this condition;
   b) Predict whether I am or am not at risk for developing this condition;
   c) Indicate whether I am or am not a carrier for this condition; or
   d) Be indeterminate due to limitations of current technology.
2. This genetic analysis may be specific only for the condition named above. It will not detect all mutations possible within this gene nor detect mutations in other genes.
3. The significance of a positive and a negative test result based on my family history has been explained.
4. Although mutation and/or linkage analyses usually yield precise information, several sources of error are possible, including those due to inaccurate information regarding family relatedness.
5. Through genetic analysis, the laboratory may discover false paternity. A genetic analysis may also suggest a genetic condition in another family member.
6. Genetic analysis results may cause emotional stress. All test results are treated with standard medical confidentiality. If an insurance provider requires test results for reimbursement purposes, I authorize the laboratory to release them. New Mexico and several other states have laws prohibiting discrimination by health insurers on the basis of pre-symptomatic genetic testing results.
7. Genetic analysis may involve complex, multi-part processes. Turn-around times are only estimates and cannot be guaranteed. Occasionally, the laboratory may request a second sample for genetic analysis.
8. After genetic analysis is completed, any remaining sample material may be retained, transmitted and/or used for quality assurance or education purposes or for scientific or medical research under the oversight of an Institutional Review Board. Refusal to permit the use of my sample for research will not affect this test procedure. I can withdraw my consent at any time by contacting the director of the laboratory that performed this genetic testing. **If you do not consent to the use of your sample for research, please sign here. _____**

PATIENT CONSENT: The content of this form has been explained to me by my healthcare provider and my signature indicates consent for the genetic test indicated above.

Name of Referring Physician: _____

Name of Patient: _____

Signature of Patient or Guardian: _____

Signature of Witness: _____

Date: _____