

Request for highly parallel sequencing of the complete CFTR gene

Requesting CF physician:.....

Address:.....

Country:.....

Email:.....

Tel.:.....

Code of the anonymized DNA sample (2-5µg):

Diagnosis of CF:

Sweat chloride concentration >60 mmol/L (Gibson –Cook): mmol/L

Symptoms compatible with CF:

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.....
.....

- Sibling with CF: yes no

- Positive test at newborn screening: yes no

Data at last clinic visit:

Current age (yrs months): Age at diagnosis (yrs months):

Male Female W (in kg): H (in cm):

P Sufficient P Insufficient

Chronic Pseud aeruginosa infection yes no

FEV₁ (in ml) at last visit (pts >6 yrs):

CFTR genotype results:

Routine CFTR mutation panel

Commercial vendor: yes no

If commercial test: provide name of test

If not commercial: which mutations are tested:

.....

.....

Other genetic tests have been used: yes no

If yes, indicate which.....

.....

Result CFTR genotype /

I testify that a written informed consent according to inclusion criteria is signed: yes no

Date:

Signature:

Mail this form to els.aertgeerts@uzleuven.be