



Biomnis

Clinical Information Form

Cystic fibrosis gene analysis (CFTR gene)

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PATIENT DETAILS

First(s) name(s):

Surname:

Date of birth:

Gender: F M

CLINICIAN

Surname: Dr

Address:

Post code: City:

Country:

Tel.:

TESTS REQUESTED

- Cystic Fibrosis CFTR-screening of most frequent mutations
- Cystic Fibrosis CFTR-complete genotyping by New Generation Sequencing (NGS)

FAMILY TREE

Geographical origin*:

(*the frequency and distribution of the mutations vary depending on the ethnic/geographical origin of the patient)

Consanguinity: YES (please indicate on the tree) NO

CONSULTATION CERTIFICATE AND PATIENT CONSENT FORM

(Decree n° 2008-321 of 4th April 2008, amended on 27th May 2013)

I, the undersigned,
Medical Doctor (MD), certify that I have fully informed my patient

Mr/Mrs/Miss
of the information defined according to the article R.1131-4 of decree n°2008-321 dated 4 April 2008 of the French public health code and amended on 27th May 2013 and that I have obtained written informed consent from my patient under the conditions specified in article R.1131-5.

Signed in (city)
on

Physician's signature

I, the undersigned,

Mr/Miss/Mrs
declare that I have been informed and fully understand all information relating to this analysis and give my consent to perform this genetic test, in accordance to the articles R.1131-4 and R1131-5 of the public health code and decree of 27th May 2013.

Signed in (city)
on

Patient signature

REASON BEHIND THE TEST REQUEST FOR A CHILD OR ADULT

- Suspected cystic fibrosis**
- ENT disease:
- Respiratory disease:
- Digestive system disease:
- Pancreatic affection:
- Sweat test: NO YES, result (please indicate the unit):
- Infertility**
- Bilateral absence of the vas deferens: NO YES
- Please include the ultrasound scan and test results*
- Medically assisted procreation**
- Ovum donation**
- Suspected cystic fibrosis in a foetus**
- LMP: Date of conception:
- Amniocentesis: NO YES
- Digestive enzyme assay on amniotic fluid: NO YES, results:
- Please include the ultrasound scan(s) and test results*
- Family investigation**
- Heterozygote screening of the family of a patient with cystic fibrosis
- Familial mutation to be screened for:
- Please include the CFTR gene analysis test results*
- Heterozygote screening for a partner of an afflicted individual a partner of heterozygous individual

