



CYSTIC FIBROSIS CARRIER TESTING

Patient Consent Form

Carefully read the above patient information and indicate your choice below as to whether you would like to pursue carrier testing for Cystic Fibrosis. If you have further questions, please ask your health care provider. Your doctor may wish you to speak with a genetic counselor as well.

YES, I would like Cystic Fibrosis testing. I have read and understood the information on Cystic fibrosis. I understand that a negative test result does not completely eliminate the possibility that I am a Cystic Fibrosis carrier. I understand that Cystic Fibrosis testing is entirely voluntary and that I may decline testing at any time. I accept the cost for this lab test if Cystic Fibrosis testing is not covered by my insurance. I understand that my results will be released to my doctor who in turn will be the only party informing me of my results.

NO, I do not want to have Cystic Fibrosis testing. I understand and accept the consequences of this decision.

Patient Signature: _____ Date: _____