

# Non-Screened or Screen Negative Cystic Fibrosis Case Report Form

Complete one form for each diagnosed Cystic Fibrosis patient that was not referred to your Center through California CF Newborn Screening

\_\_\_\_\_  
CF Center Name

\_\_\_\_\_  
Staff Member Completing Form

## ***Patient Information:***

CFF Patient Registry ID: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_

### **Patient's Name (Last, First, Middle Initial)**

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
MI

### **Mother's Name (Last, Maiden, First, Middle Initial)**

\_\_\_\_\_  
Last

\_\_\_\_\_  
Maiden

\_\_\_\_\_  
First

\_\_\_\_\_  
MI

### **Father's Name (Last, First, Middle Initial)**

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
MI

Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

For Race and Ethnicity, please complete as per the CF Foundation patient registry.

Sex (circle one): M or F

Birth date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Place:

\_\_\_\_\_  
Hospital

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Country

Current ZIP Code of residence: \_\_\_\_\_

## ***Medical Information:***

Mutation information: (Indicate test names, lab names, dates of tests, and results of mutations found AND/OR send a copy of the actual lab results along with this form)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date patient first seen at your center (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Location of CF diagnosis if patient was born in the years 2000-2007:

\_\_\_\_\_  
Hospital/CF Center

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Country

**After you have completed this form, please fax or mail it to:** Genetic Disease Screening Program, California Department of Public Health, 850 Marina Bay Parkway, Room F175, Mail Stop 8200, Richmond, CA 94804; **Fax: 510-412-1511**