SWEAT CHLORIDE TESTING

INFORMATION REQUEST FORM

To be completed by ordering physician:

Patient Name_________________________ Date of Birth______________

Phone #___________________(Contact phone # for patient/parents)

_______**Quantitative Sweat Chloride** (scheduled Monday- Friday, 8:30-11 am)

-Performed in duplicate. The Cystic Fibrosis Foundation requires two positive quantitative results to establish a diagnosis of Cystic Fibrosis.

________Positive Sweat Screen test

Performed where? ____________________

_______Positive Neonatal metabolic screen

_______Family history of CF

_______Other

Please explain:_______________________

Requesting Physician Contact Information:

Name____

Phone_______________________Cellphone_________________

Return via fax to Northern Plains Laboratory: (701) 530-5707