MEDICAL RECORD - CONSENT FORM

Cystic Fibrosis Carrier Test

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the cystic fibrosis carrier test. This test can identify if someone is a carrier of this disease.

By signing below I understand that--

- 1. This test is to see if I am a carrier of cystic fibrosis (CF). This means I could have the gene but not the
- 2. The risk of being a CF carrier depends on race and ethnic background.
 - a. For European Caucasian and Ashkenazi Jewish couples:
 - (1) There is a 1 in 25 chance one parent is a carrier.
 - (2) There is a 1 in 625 chance both parents are carriers.
 - b. For Hispanic American couples:
 - (1) There is a 1 in 46 chance one parent is a carrier.
 - (2) There is a 1 in 2,116 chance both parents are carriers.
 - c. For African American couples:
 - (1) There is a 1 in 65 chance one parent is a carrier.
 - (2) There is a 1 in 4,225 chance both parents are carriers.
 - d. For Asian American couples:
 - (1) There is a 1 in 80 chance one parent is a carrier.
 - (2) There is a 1 in 8,100 chance both parents are carriers.
- 3. If I am a carrier of CF, testing the baby's biological father is needed to know if my baby could have CF.
- 4. CF carrier testing is one type of DNA testing. In the event the father is determined to be another person, a family medical history from that person will be necessary.
- 5. If both parents are carriers, the baby has 1 in 4 (25%) chance of having CF. If this is the case, I may have more testing to tell whether my baby has CF. This testing may be done before or after delivery.
- 6. I am the one to decide whether or not I am tested.
- 7. The test is not perfect. Some carriers are missed by the test.
- 8. My decision to have or not have this test wil not change my military health coverage.

I have read and understand the information provided to me about cystic fibrosis. My questions have been answered to my satisfaction. Please check one:

☐ Yes, I want to have the cystic fibrosis carrier test.							
☐ No, I do not want to have the cystic fibrosis carrier test.							
Patient:	(Signature)	(Print Name)					
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Witness:	(Signature)	(Print Name)	(Date)				