

Three Rivers Pathology2664 Patton Road
Roseville, MN 55113**Molecular Diagnostic
Supplemental Requisition**

Phone: 651-635-9700

Patient Name (Last)		(First)
Address		
City	State	Zip
Chart #	SS #	Phone #

Clinician Name
_____Date Collected
____/____/____Date of Birth
____/____/____Specimen Type: ThinPrep SurePath Swab Specimen Site: _____**Ethnic Heritage** (applicable to CF only) - check all that apply:

- Asian Caucasian (non-Hispanic) Jewish Ashkenazi Native American
 African American Hispanic Jewish (other) Other _____

Inherited Thrombophilia (IHT) - check all that apply:

- Factor V Leiden G191A
 Factor II Prothrombin G20210A
 MTHFR C677T

Reason for Testing/Patient History - check all that apply:

- Women's Health
e.g. Oral Contraceptives, Hormone Replacement or Recurrent Fetal Loss
 Surgery
 Prolonged Immobilization
 Cancer
 History of Venous Thrombosis
 Patient
 Family

Cystic Fibrosis (CF) Mutation Screening

- CF Panel for 29 Mutations
 (23 ACOG/ACMG Recommended + 6 Additional Mutations)

Reason for Testing/Patient History - check all that apply:

- Carrier Screening (no known family history of CF)
 Carrier Screening (known family history of CF)
 Patient Affected Family Member
 Sibling
 Aunt/Uncle
 Niece/Nephew/Half Sibling
 Parent
 Cousin
 Other _____
 Patient's family member is a known CF carrier
 Partner is a known carrier
 Congenital absence of the vas deferens
 Individual with CF symptoms
 Other _____