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 disease.
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) (Date)

Witness: _____ _____ _____
(Signature) (Print Name) (Date)