

Thalassemia/Hemoglobinopathy Information Sheet

To help us provide the best possible service, supply the information requested below. All of this information is important for interpretation of test results. Answer the questions completely. All answers will be kept confidential.

Patient Information

Patient Name (Last, First, Middle Initial)	Birth Date (Month DD, YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Physician	Physician Phone	Fax Number
Physician E-mail		
Ethnic Origin/Race <input type="checkbox"/> European <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> African <input type="checkbox"/> Jewish <input type="checkbox"/> Irish <input type="checkbox"/> Other _____		

Clinical History

Family history of similar disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this patient pregnant or is testing being performed for genetic counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have known hemoglobinopathy diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate diagnosis_____	
Recent transfusion history <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date(s) of last transfusion(s)_____	
Splenomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No	Hydroxyurea treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoglobin concentration_____ MCV _____ RBC _____ RDW _____ WBC _____ HCT _____ Ferritin _____ Reticulocyte count (if available) _____	
Relative Clinical Information	
If electrophoretic testing is not conclusive, would you like molecular testing to be performed at an additional charge? <input type="checkbox"/> Yes <input type="checkbox"/> No	