

# Thalassemia/Hemoglobinopathy

## Patient Information Sheet

**Instructions:** The information requested below is important for interpretation of test results. To help us provide the best possible service please answer the questions completely and **send the paperwork with the specimen**. All answers will be kept confidential.

### Patient Information

Patient Name <i>(Last, First, Middle Initial)</i>		Birth Date <i>(Month DD, YYYY)</i>		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Physician		Physician Phone		Fax Number
Physician E-mail				
Ethnic Origin/Race <b>Ethnic background is necessary to provide appropriate interpretation of test results.</b>				
<input type="checkbox"/> African	<input type="checkbox"/> Arab	<input type="checkbox"/> Chinese	<input type="checkbox"/> European	<input type="checkbox"/> Irish
<input type="checkbox"/> Japanese	<input type="checkbox"/> Jewish	<input type="checkbox"/> Southeast Asian	<input type="checkbox"/> Other _____	

### Clinical History

Reasons for Testing				
<input type="checkbox"/> Prenatal/Carrier testing	<input type="checkbox"/> Erythrocytosis	<input type="checkbox"/> Abnormal newborn screen		
<input type="checkbox"/> Hemolytic anemia	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Follow-up of previous results		
<input type="checkbox"/> Screening for _____	<input type="checkbox"/> Non-specific anemia	<input type="checkbox"/> Prev known hemoglobinopathy dx: _____		
<input type="checkbox"/> Sick monitor/treatment monitor	<input type="checkbox"/> Microcytosis	Previously tested at Mayo Clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other _____				
Family History				
Are other relatives known to be affected? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, explain relatives disorder				
Indicate relationship to patient				
If relative was tested at Mayo Clinic, include the name of the family member				
RBC _____	HGB _____	MCV _____	Recent transfusion history <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
RDW _____	WBC _____	HCT _____	If yes, date(s) of last transfusion(s) _____	
Ferritin _____	Splenomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No			
Reticulocyte count (if available) _____	Hydroxyurea treatment <input type="checkbox"/> Yes <input type="checkbox"/> No			
Relevant 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				