

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform hemoglobinopathy/thalassemia testing.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR HEMOGLOBINOPATHY/THALASSEMIA TESTING

Patient's Name _____ Date of Birth ____/____/____ Gender F M

Physician _____ Physician Phone (____) _____ Practice Specialty _____

Genetic Counselor _____ Counselor Phone (____) _____

PATIENT'S ETHNICITY (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian (N Europe) | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> African (specify region _____) | <input type="checkbox"/> Caucasian (S Europe) | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Asian Southeast | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other _____ |

REASONS FOR TESTING (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Abnormal newborn screen (describe result: _____) | <input type="checkbox"/> Confirm a suspected diagnosis in a symptomatic patient |
| <input type="checkbox"/> Carrier screening for a healthy individual without symptoms | <input type="checkbox"/> Disease management |
| <input type="checkbox"/> Other _____ | |

Does the patient have SYMPTOMS? No Yes (check all that apply)

- Anemia (has iron deficiency been excluded? No Yes Unknown)
 Splenomegaly Polycythemia Cyanosis
 Diabetes mellitus (hemoglobin A1c: _____)
 Other _____

Has the patient had a recent TRANSFUSION? No Yes (date of transfusion: _____) Unknown

LABORATORY FINDINGS

Hemoglobin evaluation by electrophoresis or HPLC (date performed : _____)
Hb A% _____ Hb A₂% _____ Hb F% _____ Hb Bart% _____ Hb H% _____ Other _____
Hemoglobin concentration: _____ HCT: _____ MCV: _____ Reticulocyte count: _____

FAMILY HISTORY OF HEMOGLOBINOPATHY/ THALASSEMIA? No Yes Unknown

If yes, what is the **RELATIONSHIP** of family member(s) to the patient? _____
Is the relative? a healthy carrier affected
List the **GENE and MUTATION(S)** identified or include a copy of the laboratory result: _____

HAS DNA TESTING BEEN PERFORMED PREVIOUSLY FOR THIS PATIENT? No Yes Unknown

If yes, please check the completed test(s) and provide result or attach report.

- | | |
|---|---------------|
| <input type="checkbox"/> Alpha globin deletion analysis | Result: _____ |
| <input type="checkbox"/> Beta globin sequencing | Result: _____ |
| <input type="checkbox"/> Other | Result: _____ |

Circle the test you intend to order.

- 0051495 Alpha Thalassemia (HBA1 & HBA2) 7 Deletions:** Test for seven common *HBA1* and *HBA2* deletions associated with alpha thalassemia; clinical sensitivity is ~ 90%.
- 2001582 Alpha Thalassemia (HBA1 & HBA2) Sequencing:** Clinical sensitivity is ~ 10% for alpha thalassemia.
- 0050578 Beta Globin (HBB) Sequencing:** Clinical sensitivity for beta thalassemia ~ 97%.
- 0051421 Beta Globin Gene Mutations for HbS, HbC, HbE by PCR:** Tests for the common Hb S, Hb C and Hb E mutations.
- 2001961 Familial Mutation, Targeted Sequencing:** Tests for a previously identified familial mutation; relative's lab result is REQUIRED.
- 2005792 Hemoglobin Evaluation Reflexive Cascade**
- 0050610 Hemoglobin Evaluation with Reflex to Electrophoresis and/or RBC Solubility**
- 2004686 Hemoglobin Lepore (HBD/HBB Fusion) 3 Mutations**
- 2005408 Hereditary Persistence of Fetal Hemoglobin (HPFH) 8 Mutations**
- 2002984 Oxygen Dissociation (P50) by Hemoximetry**

For questions, contact a genetic counselor at (800) 242-2787, ext. 2141.

Master Label