

MEHARRY SICKLE CELL CENTER
 Attn: Lab Supervisor
 1005 Dr. D.B. Todd, Jr Blvd., A-10
 Nashville, TN 37208
 PHONE (615) 327-6763
 FAX (615) 327-6008
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(ANYONE OVER 1 YEAR OF AGE)

LABORATORY REQUEST FORM FOR HEMOGLOBINOPATHIES
ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS SAMPLE.-PLEASE PRINT

LAST NAME		FIRST NAME		MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	FOR MSCC LAB USE ONLY LAB# _____ RESULTS: AA: _____ OTHER _____ TECH: _____ DATE: ___/___/___ DIR: _____ DATE: ___/___/___
STREET ADDRESS		CITY	STATE	ZIP		
COUNTY	SS#	PHONE (MUST INCLUDE AREA CODE): () -				
DOB ____/____/____	RACE: <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____		ETHNICITY: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino			
TRANSFUSED <input type="checkbox"/> YES (DATE: ___/___/___) <input type="checkbox"/> NO						DATE COLLECTED: ___/___/___ Time: _____ Family Study: Y N Relationship: _ _____ Repeat: Y N Previous Results: _____
I hereby consent to the drawing of 5 ml or less of blood for laboratory tests to determine the type(s) and or quantities of hemoglobin(s) by protein chemistry tests or DNA analysis (if needed). These tests have been explained to me in terms of their purpose, risks, and care used to avoid complications. I certify that the results of this Hemoglobinopathy test will not be used for athletic testing unless the appropriate fee has been paid to Meharry Medical College. Signature of Participant / Guardian: _____ Date: _____ Signature of Witness: _____ Date: _____ Reason for Guardian (coma, minor, incompetent, etc.): _____ Signature of Consenting Authority: _____ Relationship of Consenting Authority: _____						MAIL RESULTS TO: PCP: _____ Email address _____ _____ Agency _____ Address: _____ City _____ State _____ Zip _____ Phone: _____ Fax: _____

BEFORE SIGNING THIS FORM PLEASE READ AND INITIAL THE FOLLOWING: The purpose of the test is to determine whether you have Sickle Cell Anemia, Sickle Cell Trait, or any other detectable unusual type of hemoglobin. The risks are minimal (small). If you participated at a designated clinic or received a referral to the center from your physician the results will be placed in your medical records unless you refuse. All self-referral or walk-in clients will receive results in complete confidence. We will notify Meharry self-referral or walk-in clients of their test results and offer genetic counseling.

Initial _____ **Date:** _____