THIS FORM MUST ACCOMPANY SPECIMEN TDH #
MUST BE FILLED IN

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
E-mail: sickle_cell@mmc.edu

MEHARRY MEDICAL COLLEGE
Sickle Cell • CENTER

NEWBORN PATIENTS
Less than 1 year of age

LABORATORY REQUEST FORM FOR HEMOGLOBINOPATHIES

CHILD INFORMATION (PLEASE PRINT)

PEDIATRIC PATIENTS

LAST NAME:	FIRST NAME:		MI:	GENDER: (M) (F)
STREET:	CITY:	STATE:	ZIP:	COUNTY:
REGION:	SS#: xxx-xx-_____	PHONE:	**Date of Collection:**	**DOB (Date of Birth):**
TRANSFUSED? N or Y (DATE_____)	BIRTH WT:_____lbs_____oz		PREMATURE: Y or N	

RACE: Black/African-American __ American Indian/Alaskan Native __ Asian __ White __
Native Hawaiian/Pacific Islander ____ Other:_____

ETHNICITY:
__ Hispanic/Latino _ _ Non Hispanic/Latino

FOR MSCC LAB USE ONLY:

LAB #_____

RESULTS:

AA:_____OTHER:_____
TECH:_____DATE:_____
DIR:_____DATE:_____

MOTHER'S INFORMATION (PLEASE PRINT)

LAST NAME:	FIRST NAME	MI:	MARITAL STATUS S or M
STREET:	CITY:	STATE:	ZIP: SS#:

MOTHER TESTED? N or Y (DATE_____) RESULTS:_____

FATHER'S INFORMATION (PLEASE PRINT)

LAST NAME:	FIRST NAME	MI:	MARITAL STATUS M or S
STREET:	CITY:	STATE :	ZIP: SS#:

FATHER TESTED? N or Y (DATE_____) RESULTS:_____

TN DEPT OF HEALTH (TDH)

TDH# _____

TDH RESULTS:_____

MAIL RESULTS TO:

PCP: _____

_____

Email address:

AGENCY : _____

ADDRESS

City State Zip

Phone **Fax**

I hereby consent to the drawing of one ml or less of blood for laboratory tests to determine the type(s) and or quantities of hemoglobin (s). 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 Participants/Guardian:_____**Date**:_____

Reason for Guardian (coma, minor, incompetent, etc.):_____ Signature of Witness:_____Date:_____

Signature of Consenting Authority:_____Relationship of Consenting Authority:_____

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. Taking blood samples from an arm or finger can detect any of these conditions by protein chemistry tests or DNA analysis (if needed). 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 you 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: _____