ARUP LABORATORIES

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 Name _____ Date of Birth _____/_____/_____ Gender [ ] F [ ] M

Physician _____ Physician Phone (_____)_____ Practice Specialty _____

Genetic Counselor_____Counselor Phone (_____)_____

PATIENT'S ETHNICITY (check all that apply)

[ ] African American
[ ] African (specify region_____)
[ ] Asian Indian
[ ] Asian Southeast
[ ] Caucasian (N Europe)
[ ] Caucasian (S Europe)
[ ] Chinese
[ ] Hispanic
[ ] Middle Eastern
[ ] Puerto Rican
[ ] Vietnamese
[ ] Other _____

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

[ ] Anemia (has iron deficiency been excluded? [ ] No [ ] Yes [ ] Unknown)
[ ] Splenomegaly [ ] 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 A_2%_____ Hb F%_____ Hb S%_____ Hb C%_____ Hb E%_____ Other_____
HGB: _____ 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.

[ ] Alpha globin deletion analysis Result:_____
[ ] Beta globin sequencing Result:_____
[ ] Other Result:_____

Circle the test you intend to order.

Initial screening tests for hemoglobinopathies/thalassemia:	
0050610	**Hemoglobin Evaluation with Reflex to Electrophoresis and/or RBC Solubility –** HPLC with reflex to electrophoresis and/or RBC solubility
2005792	**Hemoglobin Evaluation Reflexive Cascade –** HPLC with reflex to electrophoresis, solubility testing, or molecular analyses to identify Hb variants
Molecular tests for beta thalassemia/ hemoglobinopathies:	
2010117	**Beta Globin (*HBB*) Sequencing and Deletion/Duplication –** Clinical sensitivity for beta thalassemia ~99%.
0050578	**Beta Globin (*HBB*) Sequencing-** Clinical sensitivity for beta thalassemia ~97%.
2010113	**Beta Globin (*HBB*) Deletion/Duplication-** Clinical sensitivity varies by ethnicity.
2004686	**Hemoglobin Lepore (*HBD/HBB* Fusion) 3 Mutations**
Molecular tests for alpha thalassemia:	
2011708	**Alpha Globin (*HBA1* and *HBA2*) Sequencing and Deletion/Duplication-** Clinical sensitivity is 99%
2011622	**Alpha Globin (*HBA1* and *HBA2*) Deletion/Duplication-** Clinical sensitivity up to 95% Assesses for common, rare and novel deletions and duplications.
0051495	**Alpha Thalassemia (*HBA1 & HBA2*) 7 Deletions –** Clinical sensitivity up to 90%. Assesses for 7 common large deletions.
2001582	**Alpha Thalassemia (*HBA1 & HBA2*) Sequencing –** Clinical sensitivity is ~10%.

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

Master Label