

THIS IS NOT A TEST REQUEST FORM.
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:** _____ **Sex:** Female Male
Physician: _____ **Physician Phone:** _____
Practice Specialty: _____ **Physician Fax:** _____
Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity: (check all that apply)

- African (specify region): _____ Asian (Indian) Caucasian (S Europe) Middle Eastern Other: _____
 Asian (Southeast) Chinese Puerto Rican _____
 African-American Caucasian (N Europe) Hispanic Vietnamese _____

Does the patient have symptoms? No Yes (check all that apply and describe)

- Anemia; Has iron deficiency been excluded? No Yes Unknown
 Splenomegaly
 Other symptoms: _____

Has the patient had a recent transfusion? No Yes; date of transfusion: _____ Unknown

Laboratory Findings: (Indicate which testing was performed and provide results, as requested)

- Hemoglobin evaluation by electrophoresis or HPLC; date performed: _____
Hb A%: _____ Hb C%: _____ Hb F%: _____ Other: _____
Hb A₂%: _____ Hb E%: _____ Hb S%: _____
 CBC; date performed: _____
HGB: _____ HCT: _____ MCV: _____ Reticulocyte count: _____ (%)

Has the patient undergone previous DNA testing? No Yes Unknown

- If yes, check the completed test(s) and provide the result or attach a copy of the laboratory report.
 Alpha globin deletion analysis; result: _____
 Beta globin sequencing; result: _____
 Other: _____

Is there any relevant family history of hemoglobinopathy/thalassemia? No Yes Unknown

If yes, specify the relative's relationship to the patient: _____; The relative is: a healthy carrier / affected
List the gene and variant(s) identified or attach a copy of the relative's laboratory result: _____

Check the test you intend to order.

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| <p><u>Initial screening tests for hemoglobinopathies/thalassemia:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 0050610 Hemoglobin Evaluation with Reflex to Electrophoresis and/or RBC Solubility: HPLC with reflex to electrophoresis and/or RBC solubility <input type="checkbox"/> 2005792 Hemoglobin Evaluation Reflexive Cascade: HPLC with reflex to electrophoresis, solubility testing, or molecular analyses to identify Hb variants <p><u>Molecular tests for beta thalassemia/hemoglobinopathies:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 2010117 Beta Globin (HBB) Sequencing and Deletion/Duplication: Clinical sensitivity for beta thalassemia ~99%. <input type="checkbox"/> 0050578 Beta Globin (HBB) Sequencing: Clinical sensitivity for beta thalassemia ~97%. <input type="checkbox"/> 2010113 Beta Globin (HBB) Deletion/Duplication: Clinical sensitivity varies by ethnicity. <input type="checkbox"/> 2004686 Hemoglobin Lepore (HBD/HBB Fusion) 3 Mutations | <p><u>Molecular tests for alpha thalassemia:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 2011708 Alpha Globin (HBA1 and HBA2) Sequencing and Deletion/Duplication: Clinical sensitivity is 99% <input type="checkbox"/> 2011622 Alpha Globin (HBA1 and HBA2) Deletion/Duplication: Clinical sensitivity up to 95% Assesses for common, rare and novel deletions and duplications. <input type="checkbox"/> 0051495 Alpha Thalassemia (HBA1 & HBA2) 7 Deletions: Clinical sensitivity up to 90%. Assesses for 7 common large deletions. <input type="checkbox"/> 2001582 Alpha Thalassemia (HBA1 & HBA2) Sequencing: Clinical sensitivity is ~10%. <p><u>Molecular test for gamma globinopathy:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 3001957 Gamma Globin (HBG1 and HBG2) Sequencing: Clinical sensitivity is unknown. |
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For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141

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