ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR HEMOGLOBINOPATHY/THALASSEMIA TESTING

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have clinical findings? ..... ☐ 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

Has the patient received gene therapy? ☐ No ☐ Yes; date_____; type: ☐ Lyfgenia ☐ Zynteglo ☐ Casgevy ☐ Other: _____

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

☐ Hemoglobin evaluation by electrophoresis or HPLC; date performed: _____

HbA%: _____ HbC%: _____ HbF%: _____ Other: _____

HbA_2%: _____ HbE%: _____ HbS%: _____ _____

☐ 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: _____

Master Label

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.