ARUP LABORATORIES

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

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

HEREDITARY HEMOLYTIC ANEMIA CASCADE KIT PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

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

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

Genetic Counselor: _____ **Counselor Phone:** _____

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

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

List country of origin (if known): _____

Suspected clinical diagnosis: _____

Does the patient have symptoms of a hereditary hemolytic anemia disorder?..... ☐ No ☐ Yes (Check all that apply)

☐ Anemia
☐ Fatigue
☐ Gallstones
☐ Hemolytic crisis
☐ Jaundice
☐ Splenomegaly
☐ Other symptom(s): _____

Laboratory Findings (Please attach recent CBC or provide values below)

CBC date: _____

RBC: _____

HGB: _____

HCT: _____

MCV: _____

MCHC: _____

RDW: _____

Retic: _____

Recent Transfusion History: _____

Additional Clinical Information: _____

_____

Master Label

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