MAYO CLINIC
Mayo Medical Laboratories

Thalassemia/Hemoglobinopathy Patient Information Sheet

Instructions: The information requested below is important for interpretation of test results. To help us provide the best possible service please answer the questions completely and **send the paperwork with the specimen.** All answers will be kept confidential.

Patient Information

Patient Name *(Last, First, Middle Initial)*

Birth Date *(Month DD, YYYY)*

Sex
☐ Male
☐ Female

Primary Physician

Physician Phone

Fax Number

Physician E-mail

Ethnic Origin/Race **Ethnic background is necessary to provide appropriate interpretation of test results.**

☐ African ☐ Arab ☐ Chinese ☐ European ☐ Irish

☐ Japanese ☐ Jewish ☐ Southeast Asian ☐ Other________________

Clinical History

Reasons for Testing

☐ Prenatal/Carrier testing
☐ Hemolytic anemia
☐ Screening for ________________
☐ Sickle monitor/treatment monitor
☐ Other________________

☐ Erythrocytosis
☐ Cyanosis
☐ Non-specific anemia
☐ Microcytosis

☐ Abnormal newborn screen
☐ Follow-up of previous results
☐ Prev known hemoglobinopathy dx: ________
Previously tested at Mayo Clinic? ☐ Yes ☐ No

Family History
Are other relatives known to be affected? ☐ Yes ☐ No

If yes, explain relatives disorder

Indicate relationship to patient

If relative was tested at Mayo Clinic, include the name of the family member

RBC ________ HGB ________ MCV ________

RDW ________ WBC ________ HCT ________

Ferritin________

Reticulocyte count (if available)________

Recent transfusion history ☐ Yes ☐ No ☐ Unknown

If yes, date(s) of last transfusion(s)________________

Splenomegaly ☐ Yes ☐ No

Hydroxyurea treatment ☐ Yes ☐ No

Relevant Clinical Information

If electrophoretic testing is not conclusive, would you like molecular testing to be performed at an additional charge? ☐ Yes ☐ No

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