

MEHARRY SICKLE CELL CENTER  
 Attn: Lab Supervisor  
 1005 Dr. D.B. Todd, Jr Blvd., A-10  
 Nashville, TN 37208  
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 FAX (615) 327-6008  
 E-mail: sickle\_cell@mmc.edu

(ANYONE OVER 1 YEAR OF AGE)

**LABORATORY REQUEST FORM FOR HEMOGLOBINOPATHIES**  
**ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS SAMPLE.-PLEASE PRINT**

<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>MI</b>	<b>SEX</b>	<b>FOR MSCC LAB USE ONLY</b> LAB# _____  RESULTS: AA: _____ OTHER _____  TECH: _____ DATE: ___/___/___  DIR: _____ DATE: ___/___/___					
					<input type="checkbox"/> M <input type="checkbox"/> F						
<b>STREET ADDRESS</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>							
<b>COUNTY A</b> )		phone-									
<b>DOB</b> ____/____/____	<b>RACE:</b>		<b>ETHNICITY:</b>			<b>DATE COLLECTED:</b> ___/___/___					
	<input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino			Time: _____					
<b>TRANSFUSED</b>						Family Study:    Y        N    Relationship: _					
<input type="checkbox"/> YES (DATE: ___/___/___) <input type="checkbox"/> NO						Repeat:            Y        N					
I hereby consent to the drawing of 5 ml or less of blood for laboratory tests to determine the type(s) and or quantities of hemoglobin(s) by protein chemistry tests or DNA analysis (if needed). These tests have been explained to me in terms of their purpose, risks, and care used to avoid complications. <b>I certify that the results of this Hemoglobinopathy test will not be used for athletic testing unless the appropriate fee has been paid to Meharry Medical College.</b> Signature of Participant / Guardian: _____ Date: _____  Signature of Witness: _____ Date: _____  Reason for Guardian (coma, minor, incompetent, etc.): _____  Signature of Consenting Authority: _____  Relationship of Consenting Authority: _____						Previous Results: _____					
						<b>MAIL RESULTS TO:</b>					
						PCP _____					
						Email: _____					
						Agency _____					
Address: _____											
City _____ State _____ Zip _____											
Phone: _____ Fax _____											

**BEFORE SIGNING THIS FORM PLEASE READ AND INITIAL THE FOLLOWING:** The purpose of the test is to determine whether you have Sickle Cell Anemia, Sickle Cell Trait, or any other detectable unusual type of hemoglobin. The risks are minimal (small). If you participated at a designated clinic or received a referral to the center from your physician the results will be placed in your medical records unless you refuse. All self-referral or walk-in clients will receive results in complete confidence. We will notify Meharry self-referral or walk-in clients of their test results and offer genetic counseling.

Initial \_\_\_\_\_ Date: \_\_\_\_\_