ARUP LABORATORIES

**THIS IS NOT A TEST REQUEST FORM.**
**The information below is required to perform hemoglobinopathy/thalassemia testing.**
**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 _____/_____/_____ Gender [ ] F [ ] M**

**Physician _____ Physician Phone (_____)_____ Practice Specialty _____**

**Genetic Counselor_____Counselor Phone (_____)_____**

**PATIENT'S ETHNICITY** (check all that apply)

[ ] African American
[ ] African (specify region_____)
[ ] Asian Indian
[ ] Asian Southeast
[ ] Caucasian (N Europe)
[ ] Caucasian (S Europe)
[ ] Chinese
[ ] Hispanic
[ ] Middle Eastern
[ ] Puerto Rican
[ ] Vietnamese
[ ] Other _____

**Does the patient have SYMPTOMS?** [ ] No [ ] Yes (check all that apply)

[ ] Anemia (has iron deficiency been excluded? [ ] No [ ] Yes [ ] Unknown)
[ ] Splenomegaly [ ] Other _____

**Has the patient had a recent TRANSFUSION?** [ ] No [ ] Yes (date of transfusion: _____) [ ] Unknown

**LABORATORY FINDINGS**

Hemoglobin evaluation by electrophoresis or HPLC (date performed :_____)

Hb A%_____ Hb $A_2$%_____ Hb F%_____ Hb S%_____ Hb C%_____ Hb E%_____ Other_____
HGB: _____ HCT: _____ MCV: _____ Reticulocyte count: _____(_____%)

**FAMILY HISTORY OF HEMOGLOBINOPATHY/ THALASSEMIA?** [ ] No [ ] Yes [ ] Unknown

If yes, what is the **RELATIONSHIP** of family member(s) to the patient? _____
Is the relative? [ ] a healthy carrier [ ] affected
List the **GENE and MUTATION(S)** identified or include a copy of the laboratory result: _____

**HAS DNA TESTING BEEN PERFORMED PREVIOUSLY FOR THIS PATIENT?** [ ] No [ ] Yes [ ] Unknown

If yes, please check the completed test(s) and provide result or attach report.

[ ] Alpha globin deletion analysis Result:_____
[ ] Beta globin sequencing Result:_____
[ ] Other Result:_____

## Circle the test you intend to order.

| | |
|---|---|
| **Initial screening tests for hemoglobinopathies/thalassemia:** | |
| **0050610** | **Hemoglobin Evaluation with Reflex to Electrophoresis and/or RBC Solubility –** HPLC with reflex to electrophoresis and/or RBC solubility |
| **2005792** | **Hemoglobin Evaluation Reflexive Cascade –** HPLC with reflex to electrophoresis, solubility testing, or molecular analyses to identify Hb variants |
| **Molecular tests for beta thalassemia/ hemoglobinopathies:** | |
| **2010117** | **Beta Globin (*HBB*) Sequencing and Deletion/Duplication –** Clinical sensitivity for beta thalassemia ~99%. |
| **0050578** | **Beta Globin (*HBB*) Sequencing-** Clinical sensitivity for beta thalassemia ~97%. |
| **2010113** | **Beta Globin (*HBB*) Deletion/Duplication-** Clinical sensitivity varies by ethnicity. |
| **2004686** | **Hemoglobin Lepore (*HBD/HBB* Fusion) 3 Mutations** |
| **Molecular tests for alpha thalassemia:** | |
| **2011708** | **Alpha Globin (*HBA1* and *HBA2*) Sequencing and Deletion/Duplication-** Clinical sensitivity is 99% |
| **2011622** | **Alpha Globin (*HBA1* and *HBA2*) Deletion/Duplication-** Clinical sensitivity up to 95% Assesses for common, rare and novel deletions and duplications. |
| **0051495** | **Alpha Thalassemia (*HBA1 & HBA2*) 7 Deletions –** Clinical sensitivity up to 90%. Assesses for 7 common large deletions. |
| **2001582** | **Alpha Thalassemia (*HBA1 & HBA2*) Sequencing –** Clinical sensitivity is ~10%. |

**For questions, contact a genetic counselor at (800) 242-2787, ext. 2141.**

Master Label