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MAYO CLINIC
Mayo Medical Laboratories

Thalassemia/Hemoglobinopathy Information Sheet

To help us provide the best possible service, please supply the information requested below. All of this information is important for interpretation of test results. Please answer the questions completely. All answers will be kept confidential.

Patient Name *(Last, First, Middle Initial)*	Birth Date *(Month DD, YYYY)*	Sex ☐ Male ☐ Female

Ethnic Origin/Race

☐ European ☐ Southeast Asian ☐ Chinese ☐ Japanese ☐ African

☐ Jewish ☐ Irish ☐ Other_____

Family History of Similar Disorder: ☐ Yes ☐ No	Primary Physician	Physician Phone

Recent Transfusion History

☐ Yes ☐ No ☐ Unknown

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

Splenomegaly ☐ Yes ☐ No	Hydroxyurea Treatment ☐ Yes ☐ No

Hemoglobin concentration:_____ MCV: _____ RBC: _____

RDW: _____ WBC: _____ HCT: _____

Reticulocyte count (if available):_____

Relative clinical information:

If a hemoglobinopathy/thalassemia is detected and preliminary testing is not conclusive, would you like molecular testing to continue at an additional charge? ☐ Yes ☐ No

Print

MML Supply T358
MC1235-36rev0409