MEHARRY MEDICAL COLLEGE
Sickle Cell • CENTER

ADULT PATIENTS

MEHARRY SICKLE CELL CENTER
Attn: Lab Supervisor
1005 Dr. D.B. Todd, Jr Blvd., A-10
Nashville, TN 37208
PHONE (615) 327-6763
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

LAST NAME	**FIRST NAME**	**MI**	**SEX** ☐ M ☐ F
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
COUNTY A)	phone-		

~~FOR MSCC LAB USE ONLY~~
LAB#_____
RESULTS:
AA: _____ OTHER_____
TECH: _____ DATE: ___/__/
DIR: _____ DATE: ___/___/___

DOB
_____/_____/_____

RACE:
- ☐ Black/African-American
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other_____

ETHNICITY:
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

TRANSFUSED
- ☐ YES (DATE:___/___/___)
- ☐ NO

DATE COLLECTED:___/___/___
Time:_____
Family Study: Y N Relationship: _____
Repeat: Y N
Previous Results: _____

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. **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**.
Signature of Participant / Guardian:_____Date: _____
Signature of Witness:_____Date: _____
Reason for Guardian (coma, minor, incompetent, etc.): _____
Signature of Consenting Authority: _____
Relationship of Consenting Authority:_____

MAIL RESULTS TO:
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 you 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:_____