ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR HEMOGLOBINOPATHY/THALASSEMIA TESTING

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)
☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have symptoms? ..... ☐ No ☐ Yes (check all that apply and describe)
☐ Anemia: Has iron deficiency been excluded? ..... ☐ No ☐ Yes ☐ Unknown
☐ Splenomegaly ☐ Other symptoms: _____

Has the patient had a recent transfusion? ..... ☐ No ☐ Yes; date of transfusion: _____ ☐ Unknown

Laboratory Findings: (Indicate which testing was performed and provide results, as requested.)
☐ Hemoglobin evaluation by electrophoresis or HPLC; date performed: _____
Hb A%: _____ Hb C%: _____ Hb F%: _____ Other: _____
Hb A_2%: _____ Hb E%: _____ Hb S%: _____ _____

☐ CBC: date performed: _____ HGB: _____ HCT: _____ MCV: _____ Reticulocyte count: _____(_____%)

Has the patient undergone previous DNA testing? ..... ☐ No ☐ Yes ☐ Unknown
If yes, check the completed test(s) and provide the result or attach a copy of the laboratory report.
☐ Alpha globin deletion analysis; result: _____
☐ Beta globin sequencing; result: _____
☐ Other: _____

Is there any relevant family history of hemoglobinopathy/thalassemia? ..... ☐ No ☐ Yes ☐ Unknown
If yes, specify the relative's relationship to the patient: _____; The relative is: ☐ a healthy carrier / ☐ affected
List the gene and variant(s) identified or attach a copy of the relative's laboratory result: _____

Check 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 is ~99%.

☐ **0050578 Beta Globin (HBB) Sequencing:** Clinical sensitivity for beta thalassemia is ~97%.

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%.

Molecular test for gamma globinopathy:

☐ **3001957 Gamma Globin (HBG1 and HBG2) Sequencing:** Clinical sensitivity is unknown.

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.

Master Label