



Instructions: The information requested below is important for interpretation of test results. To help us provide the best possible service, answer the questions completely and **send the paperwork with the specimen**. All answers will be kept confidential.

Patient Information

Patient Name (Last First, Middle)		Birth Date (mm-dd-yyyy)
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose	Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	

Referring Provider Information

Referring Provider Name (Last, First)	Phone	Email
---------------------------------------	-------	-------

Reason for Testing See Benign Hematology Evaluation Comparison

Hemoglobin Disorder (consider THEV1 or HBEL1) <input type="checkbox"/> Genetic counseling or prenatal <input type="checkbox"/> Abnormal newborn screen <input type="checkbox"/> Anemia <input type="checkbox"/> Microcytosis <input type="checkbox"/> Other: _____ <input type="checkbox"/> Monitoring of Hb fractions (order HGBCF) <input type="checkbox"/> Cyanosis/Hypoxia (order MEV1)	Hemolytic Anemia (consider HAEV1, RBCME, or EEEV1) Suspect <input type="checkbox"/> HS <input type="checkbox"/> HE <input type="checkbox"/> HPP <input type="checkbox"/> HSt <input type="checkbox"/> Enzyme disorder: _____ Enzyme level, if decreased: _____ Coombs: <input type="checkbox"/> Pos <input type="checkbox"/> Neg Splenectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No OF: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased EMA: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased	Erythrocytosis (consider REVE2) JAK2 V617F: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done JAK2 Exon 12: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done Serum Epo: _____ Phlebotomy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Smoker <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Cardio/pulmonary Hx <input type="checkbox"/> _____
--	--	--

Ancestry Check all that apply.

<input type="checkbox"/> African <input type="checkbox"/> Arab <input type="checkbox"/> European Caucasian <input type="checkbox"/> Latino/Latina <input type="checkbox"/> Mediterranean <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Other; specify: _____

Clinical History

CBC Data HGB: _____ HCT: _____ RBC: _____ MCV: _____ MCH: _____ MCHC: _____ RDW: _____ Retics: _____ Ferritin: _____	Relevant Clinical Information <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic (describe): _____ <input type="checkbox"/> Acquired <input type="checkbox"/> Lifelong/familial Recent transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No Last transfusion date (mm-dd-yyyy): _____ Hydroxyurea: <input type="checkbox"/> Yes <input type="checkbox"/> No Family history: <input type="checkbox"/> Yes <input type="checkbox"/> No Disorder/relation to patient: _____ Blood smear shows: _____
--	---

Test Reflex Options

As part of HBEL1, THEV1, HAEV1, REVE2, and MEV1 evaluations, the following 5 options are available:

1. Do **NOT** perform molecular testing.
2. Add only alpha globin deletion/duplication testing for common alpha thalassemias.
3. Mayo expert selection of relevant molecular testing (if needed) to explain/exclude: _____
4. Perform the following tests regardless of protein results: _____
5. Perform full genotyping (alpha, beta, gamma sequencing and deletions/duplications).

Additional Clinical Information

_____ _____
